MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 08996

09019 CERTIFICATE OF DEATH Reg. Dist. No. 25

1. PLACE OF DEATH: COUNTY A. A. MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brooklyn Hghts
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS 506 Wood St.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE A. A. COUNTY
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brooklyn Hghts
STREET ADDRESS (If rural give location) 506 Wood St.

3. NAME OF DECEASED: (First) MARY (Middle) E. (Last) ATKINSON
4. DATE OF DEATH: (Month) 10. (Day) 8 (Year) 1954

5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
F	W	W	8.25.85	69 yrs.				

10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired): Housework
10b. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (State or foreign country): Baltimore
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Joslon Van Dant
14. MOTHER'S MAIDEN NAME: Eliz. Wooden

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT & ADDRESS: Family - Same

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — Interval Between Onset And Death

Immediate cause (a) Acute Heart Failure
DUE TO
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) Arteriosclerotic Cardio-Vascular Disease
DUE TO
(c) secondary anemia.

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURED While at Work ☐ Not While At Work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from October, 1953, to October 8, 1954, that I last saw the deceased alive on Oct. 6, 1954, and that death occurred at Oct. 8, 1954 at 11:35 AM, from the causes and on the date stated above.
SIGNATURE (Degree or title) ADDRESS DATE SIGNED

23. BURIAL, CREMATION, REMOVAL (Specify)
DATE THEREOF 10.12.54
NAME OF CEMETERY OR CREMATORY Baltimore
LOCATION (City, town, or county) (State) Baltimore
DATE REC'D BY LOCAL REGISTRAR October 9, 1954
REGISTRAR'S SIGNATURE R.W.
24. FUNERAL DIRECTOR ADDRESS 130 E. Fort Ave.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

Item 21f FilmG172 10-28-54 ams

MARYLAND STATE DEPARTMENT OF HEALTH

18997

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

09020

Reg. Dist. No. 21

1. PLACE OF DEATH: COUNTY A. A. MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Highland Beach
LENGTH OF STAY (In this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY A. A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Highland Beach
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print): (First) John (Middle) Walter (Last) Aytch
4. DATE OF DEATH: (Month) Oct. (Day) 16 (Year) 1954

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
male	Colored	married	Sept 25 1903	51 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Oysterman		Stevensville Md	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
James Aytch	Elizabeth Johnson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT AND ADDRESS
		Julia A Aytch

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

9348

Immediate cause (a) Drowning — Interval between onset and death: Sudden

Antecedent cause(s) Disease or conditions, if any, giving rise to the above cause stating the underlying cause last
(b)
(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☑

21. EXTERNAL CAUSE WAS PRIMARY ☑ OR CONTRIBUTING ☐ CAUSE OF DEATH.	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY Highland Beach	(CITY OR TOWN)	(COUNTY) A.A.Co.	(STATE) Md.

TIME OF INJURY (Month)	(Day)	(Year)	(Hour)	INJURY OCCURRED While at work ☐	Not while at work ☑	HOW DID INJURY OCCUR?
10	16	54	P m.			Fell out of Boat during storm Hurricane

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐*

SIGNATURE (Degree or title)	ADDRESS	DATE SIGNED
Thomas Lacat.	MD Annapolis Md	10/19/54.

23. DISPOSITION (BURIAL, CREMATION, REMOVAL, OTHER)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
Buried	Oct 19/54	Brewer Hill	Annapolis	Md

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
10/19/54	H. C. Brewer	T. B. Johnson	Annapolis

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A16A

RECEIVED
OCT 21 1954
BUREAU V. S.

MARYLAND 08992

08998

STATE DEPARTMETT OF HEALTH

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH
COUNTY A A. MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
LENGTH OF STAY (in this place) 10
HOSPITAL OR INSTITUTION OR STREET ADDRESS 720 Springdale Ave.

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE Md COUNTY A A
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
STREET ADDRESS (If rural, give location) 720 Springdale Ave

3. NAME OF DECEASED (Type or Print) (First) Laura (Middle) Anna (Last) Baker

4. DATE OF DEATH (Month) 10 (Day) 9 (Year) 1954

5. SEX Female

6. COLOR OR RACE White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widow

8. DATE OF BIRTH 2-26-1878

9. AGE last birthday 76 yrs. If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife

10b. KIND OF BUSINESS OR INDUSTRY Home

11. BIRTHPLACE (State or foreign country) Maytown Ohio

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME Daniel Smothers

14. MOTHER'S MAIDEN NAME Angeline Sebring

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT AND ADDRESS Ralph R. Baker Annapolis Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.1 Immediate cause (a) Coronary occlusion — Interval between onset and death 1/2 h

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Coronary artery disease

(c) Sen. arteriosclerosis

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 0

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 9/14, 1954, to 10/9, 1954, that I last saw the deceased alive on 10/9, 1954, and that death occurred at 9:20 P m., from the causes and on the date stated above.

SIGNATURE (Degree or title) C. Bowman M.D. ADDRESS Annapolis Md DATE SIGNED 10/11/54

23. ~~BURIAL~~, ~~CREMATION~~ REMOVAL (Specify) DATE 10-12-54 NAME OF CEMETERY OR CREMATORY Etterbeim Cemt LOCATION (City, town, or county) Westerville (State) Ohio

DATE REC'D BY LOCAL REG. OCT. 11, 1954 REGISTRAR'S SIGNATURE [signature]

24. FUNERAL DIRECTOR John M. Layton Sons ADDRESS Annapolis Md.

MARGIN RESERVED FOR BINDING

RECEIVED
OCT 14 1954
BUREAU V. S.

MARYLAND 09021

68999
STATE DEPARTMETT OF HEALTH

CERTIFICATE OF DEATH

Reg. Dist. No.....

1. PLACE OF DEATH
COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN MAGothy Shores. Rural
LENGTH OF STAY (in this place) 6 mo.
HOSPITAL OR INSTITUTION OR STREET ADDRESS Mill Creek Road

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE MD. COUNTY Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Magothy Shores.
STREET ADDRESS (If rural, give location) P. O. Box 159 Arnold

3. NAME OF DECEASED (Type or Print) (First) MARie (Middle) Anna (Last) Birx

4. DATE OF DEATH (Month) Oct. (Day) 31, (Year) 1954.

5. SEX F.

6. COLOR OR RACE W.

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)

8. DATE OF BIRTH June 26, 1887.

9. AGE last birthday 67. yrs. If under 1 year Months. Days. If under 24 hrs. Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife.

10b. KIND OF BUSINESS OR INDUSTRY Home.

11. BIRTHPLACE (State or foreign country) MARYLAND.

12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME William HASelhorst.

14. MOTHER'S MAIDEN NAME [redacted] Maggie Berger.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service) yes

16. SOCIAL SECURITY No. none

17. INFORMANT AND ADDRESS Mrs Aurora Shivers MAGothy shores. MD.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Respiratory & Circulatory Failure. 4 yrs.

Antecedent cause(s) Arteriosclerotic Cardiovascular

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Disease - hypertension -

(c) Arthritis - osteoporosis.

4435

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION None

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify) None

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 21 Oct., 1954 to 31 Oct., 1954, that I last saw the deceased alive on 31 Oct., 1954 and that death occurred at 5:33 P m., from the causes and on the date stated above.

SIGNATURE (Degree or title) Robert R. Hahn M.D. ADDRESS Severna Park Md DATE SIGNED 31 Oct. 1954

23. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | DATE 11/3/54 | NAME OF CEMETERY OR CREMATORY MEADOWRIDGE | LOCATION (City, town, or county) Howard County (State) Md.

DATE REC'D BY LOCAL REG. | REGISTRAR'S SIGNATURE A. E. Hedrick

24. FUNERAL DIRECTOR George L. Schwab ADDRESS 2101 Fredericksburg

DLK

MARGIN RESERVED FOR BINDING

MARYLAND 08993

STATE DEPARTMETT OF HEALTH 69000

CERTIFICATE OF DEATH

Reg. Dist. No.....

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH
COUNTY Anne A undel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
MARYLAND
LENGTH OF STAY (In this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Anne Arundel General Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE Maryland COUNTY Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
STREET ADDRESS (If rural, give location) 44 West Street

3. NAME OF DECEASED (Type or Print) (First) LENA (Middle) MILLER (Last) BLOOM

4. DATE OF DEATH (Month) (Day) (Year) Oct. 4, 1954 19

5. SEX Female

6. COLOR OR RACE White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married

8. DATE OF BIRTH Nov. 19, 1900

9. AGE last birthday 53 yrs. If under 1 year: Months, Days. If under 24 hrs.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife

10b. KIND OF BUSINESS OR INDUSTRY Own Home

11. BIRTHPLACE (State or foreign country) Baltimore, Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Abrahma Miller

14. MOTHER'S MAIDEN NAME Dena Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) ---

16. SOCIAL SECURITY NO. (If year, give war or dates of service) ---

17. INFORMANT AND ADDRESS Mr. Benjamin Bloom Husband same as # 2

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

33/X

Immediate cause (a) Cerebral Hemorrhage

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) with Rt. Hemiplegia

(c) Hyper tensive Vascular Disease

INTERVAL BETWEEN ONSET AND DEATH

(a) 2 weeks

(b) several years

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Sept 15, 1954, to Oct 4, 1954, that I last saw the deceased alive on Oct 4, 1954, and that death occurred at 130 A m., from the causes and on the date stated above.

SIGNATURE (Degree or title) George C Bard M.D. ADDRESS Annapolis Md DATE SIGNED 10-5-54

23. BURIAL, CREMATION REMOVAL (Specify) Burial

DATE Oct. 5, 1954

NAME OF CEMETERY OR CREMATORY Kenesith Israel Cemetery

LOCATION (City, town, or county) (State) Annapolis, Maryland

DATE REC'D BY LOCAL REG. Oct. 5, 1954

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR Ben L. Hopping and Son ADDRESS Annapolis, Md.

RECEIVED
OCT 6 1954
BUREAU V. S.

Item 18 Film G179 3-28-55 ams

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 10015

09022

CERTIFICATE OF DEATH

Reg. Dist. No. 22

1. PLACE OF DEATH:
COUNTY Anne Arundel MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort George G Meade
LENGTH OF STAY (in this place) 21 years
HOSPITAL OR INSTITUTION OR STREET ADDRESS US Army Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY -
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 03 X-2
STREET ADDRESS (If rural give location) 1213 White Avenue (Rosedale)

3. NAME OF DECEASED: (Type or Print) (First) Olga (Middle) Marie (Last) Blount

4. DATE OF DEATH: (Month) October (Day) 31 (Year) 1954

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married

8. DATE OF BIRTH: 12 February 1933

9. AGE last birthday 21 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10B. KIND OF BUSINESS OR INDUSTRY: -

11. BIRTHPLACE (State or foreign country): Baltimore, Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: August Zorn

14. MOTHER'S MAIDEN NAME: Francess Dvorak

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service) -

16. SOCIAL SECURITY NO. 212-30-8824

17. INFORMANT & ADDRESS Husband, Gordon Blount, 1213 White Avenue

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

IMMEDIATE CAUSE

ANTECEDENT CAUSE (S)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.

(A) Rheumatic heart disease, inactive, with

DUE TO involvement of mitral and aortic valve resulting

(B) in mitral and aortic insufficiency.

DUE TO

(C)

INTERVAL BETWEEN ONSET AND DEATH: 7 years

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH: Pregnancy uterine delivered.

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.

21E. INJURY OCCURRED While at work [ ] Not while at work [ ]

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 27 Sep, 1954, to 31 Oct, 1954, that I last saw the deceased alive on 31 Oct, 1954, and that death occurred at 2045 M, from the causes and on the date stated above.

SIGNATURE Bruce G. Brown BRUCE BROWN, CAPT, MC MD. ADDRESS Fort Meade DATE SIGNED 31 Oct 54

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial DATE THEREOF 4 Nov 54 NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery LOCATION (City, town, or county) Baltimore (State) Md.

DATE REC'D BY LOCAL REGISTRAR 4 Nov 54 REGISTRAR'S SIGNATURE T.E. GORDON, CWO, USA

24. FUNERAL DIRECTOR Lilly & Zeiler ADDRESS Baltimore, Md.

VS. A15—10-54

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

RECEIVED
NOV 10 1954
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 03001

CERTIFICATE OF DEATH

09023

Reg. Dist. No. 2-8

1. PLACE OF DEATH:
COUNTY Anne Arundel MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville
LENGTH OF STAY (in this place) 3 mos. 14 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS 10 Crownsville State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Baltimore City
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore City
STREET ADDRESS (If rural give location) 1622 Lorman Court.

3. NAME OF DECEASED: (Type or Print) (First) Samuel (Middle) John (Last) Blyther

4. DATE OF DEATH: (Month) 10 (Day) 8 (Year) 19 54

5. SEX: Male

6. COLOR OR RACE: Negro

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): Married

8. DATE OF BIRTH: 12/15/94

9. AGE last birthday 59 yrs. IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS.: Hours — Min. —

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Contractor

10B. KIND OF BUSINESS OR INDUSTRY: Unknown

11. BIRTHPLACE (State or foreign country): Unknown

12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME: Johny Blyther

14. MOTHER'S MAIDEN NAME: Dollie (Last name unknown)

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) Unk. (If Yes, give war or dates of service) Unk.

16. SOCIAL SECURITY NO. 248-16-8588 Unk.

17. INFORMANT & ADDRESS: Hospital Records

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

45

IMMEDIATE CAUSE (A) Generalized Arteriosclerosis — INTERVAL BETWEEN ONSET AND DEATH: Known to us since 7/24/54

ANTECEDENT CAUSE (S) DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION: — 19B. MAJOR FINDINGS OF OPERATION — 20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) — 21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) — 21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY M. — 21E. INJURY OCCURRED While at work ☐ Not while at work ☐ — 21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 7/24, 1954, to 10/8, 1954, that I last saw the deceased alive on 10/8, 1954, and that death occurred at M, from the causes and on the date stated above.

SIGNATURE M.D. — ADDRESS Crownsville, Md. — DATE SIGNED 10/8/54

23. BURIAL, CREMATION, REMOVAL (SPECIFY) — DATE THEREOF 10-11-54 — NAME OF CEMETERY OR CREMATORY U.S. Vets Corps Camden — LOCATION (City, town, or county) (State) Camden So. Carolina

DATE REC'D BY LOCAL REGISTRAR Oct. 9 1954 — REGISTRAR'S SIGNATURE R.W. — 24. FUNERAL DIRECTOR Charles G Cooper — ADDRESS 512 Carrollton Ave Balto. Md

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15—10-5

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08994

CERTIFICATE OF DEATH

09002

Reg. Dist. No. ....

Item 2, FilmG172 11-5-54 et

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH:
COUNTY Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
LENGTH OF STAY (in this place) MARYLAND
HOSPITAL OR INSTITUTION OR STREET ADDRESS Anne Arundel General Hosp.

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY A. A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN South Haven
STREET ADDRESS (If rural give location)

3. NAME OF DECEASED: (Type or Print) (First) Louis G. (Middle) (Last) Bouscaren

4. DATE OF DEATH: (Month) Oct. (Day) 20 (Year) 1954

5. SEX: male

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): widowed

8. DATE OF BIRTH: Nov. 22, 1880

9. AGE last birthday: 73 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): retired engineer

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Chattanooga, Tenn.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Jules Bouscaren

14. MOTHER'S MAIDEN NAME: Jennie Long

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT & ADDRESS: son - Harry L. Bouscaren

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Interval Between Onset And Death

Immediate cause (a) Coronary occlusion — 1/2 hr.
DUE TO

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.
(b) arteriosclerotic cardiovascular disease & hypertension — 10 yr.
DUE TO
(c)

11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: **19b. MAJOR FINDINGS OF OPERATION**

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify) PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. INJURY OCCURED While at Work ☐ Not While At Work ☐ HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 10/8 ,19 54, to 10/20 , 1954, that I last saw the deceased alive on 10/20, 1954, and that death occurred at 9:20 a.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

s/ Bouscaren MD — Annapolis Md — 10/20/54

23. BURIAL, CREMATION, REMOVAL (Specify) 10-23-54 DATE THEREOF NAME OF CEMETERY OR CREMATORY Congressional Cem. LOCATION (City, town, or county) (State) Washington, D.C.

DATE REC'D BY LOCAL REGISTRAR 10/20/54 REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR Warner E. Pumphrey ADDRESS Silver Spring, Md.

MARYLAND 08995

STATE DEPARTMENT OF HEALTH 09603

CERTIFICATE OF DEATH

Reg. Dist. No. ..... 21 .....

1. PLACE OF DEATH
COUNTY A A. MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS U. S. General

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE Md. COUNTY A A
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
STREET ADDRESS (If rural, give location) 229 West

3. NAME OF DECEASED (Type or Print) (First) Robert (Middle) L. (Last) Bowen Sr.

4. DATE OF DEATH (Month) (Day) (Year) 10 - 5 - 1954

5. SEX Male

6. COLOR OR RACE White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married

8. DATE OF BIRTH Aug 21-1884

9. AGE last birthday 70 yrs. If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Warden U. S. Jail

10b. KIND OF BUSINESS OR INDUSTRY Warden

11. BIRTHPLACE (State or foreign country) Calvert Co Md

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Hezekiah Bowen

14. MOTHER'S MAIDEN NAME Edith C. Hardesty

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)

16. SOCIAL SECURITY No.

17. INFORMANT AND ADDRESS Hazel R Bowen Annapolis Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

2 X

Immediate cause (a) Bi-Lateral Pulmonary Tuberculosis — Interval Between Onset and Death: ?

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Rheumatic Heart Disease & — ?

(c) Grade IV Jaundice — 1 Wk.

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8/10/54, to 10/15/54, that I last saw the deceased alive on 10/15/54, and that death occurred at 1:10 P. m., from the causes and on the date stated above.

SIGNATURE (Degree or title) Frank M Shipley M.D. ADDRESS Annapolis DATE SIGNED 10/6/54

23. BURIAL, CREMATION, REMOVAL (Specify) DATE Oct 8-1954 NAME OF CEMETERY OR CREMATORY Edwards Chapel LOCATION (City, town, or county) Annapolis (State) Md. A. Co.

DATE REC'D BY LOCAL REG. Oct. 6, 1954 REGISTRAR'S SIGNATURE [illegible] O. Howard

24. FUNERAL DIRECTOR John M. Taylor Sons ADDRESS Annapolis Md.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09024

CERTIFICATE OF DEATH

Reg. Dist. No. 09004 28

1. PLACE OF DEATH: Crownsville
COUNTY A. A. MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville
LENGTH OF STAY (in this place) 3 months
HOSPITAL OR INSTITUTION OR STREET ADDRESS Crownsville State Hospital.

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md. COUNTY Baltimore City
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore.
STREET ADDRESS (If rural give location) 551 Bloom Street.

3. NAME OF DECEASED: (Type or Print) (First) Carrie (Middle) (Last) Brooks.

4. DATE OF DEATH: (Month) 10 (Day) 22 (Year) 1954

5. SEX: F

6. COLOR OR RACE: N

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Seperated

8. DATE OF BIRTH: APRIL 6, 1884

9. AGE last birthday 70 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10B. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: William Streams (deceased)

14. MOTHER'S MAIDEN NAME: ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unk.) No (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO. ?

17. INFORMANT & ADDRESS: 1423 N. Bruce St, Louise Paul (niece) Baltimore Md.

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

IMMEDIATE CAUSE (A) Cerebral hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 3 months

ANTECEDENT CAUSE (S) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.

DUE TO (B) Hypertensive cardiovascular heart disease

DUE TO (C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION: 0

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D TIME OF INJURY (Month) (Day) (Year) (Hour) M.

21E INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8/2, 1954 to 10/22, 1954 that I last saw the deceased alive on 10/22, 1954 and that death occurred at 12:10 M. from the causes and on the date stated above.

SIGNATURE [signature] M.D. ADDRESS Crownsville State Hosp. DATE SIGNED 10/22/54

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial

DATE THEREOF 10-26-54

NAME OF CEMETERY OR CREMATORY St Peters cem

LOCATION (City, town, or county) (State) md

DATE REC'D BY LOCAL REGISTRAR 10/25/54

REGISTRAR'S SIGNATURE [signature]

24. FUNERAL DIRECTOR George G. Pelton ADDRESS 1303 Forrest may st

VS. A15—10-54

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

09005

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08996

CERTIFICATE OF DEATH

Reg. Dist. No. ... ..

Items 8, 13, 14 Film C172 10-28-54 et

1. PLACE OF DEATH:
COUNTY Anne Arundel — MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
LENGTH OF STAY (in this place) DOA
HOSPITAL OR INSTITUTION OR STREET ADDRESS USNH, Annapolis, Maryland

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md — COUNTY An
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Eastport, Md.
STREET ADDRESS (If rural give location) 524 3rd St. Eastport, Maryland

3. NAME OF DECEASED: (Type or Print) (First) Bulleigh (Middle) James (Last) BROXTON

4. DATE OF DEATH (Month) Oct. (Day) 21 (Year) 54

5. SEX: M

6. COLOR OR RACE: N

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): M

8. DATE OF BIRTH: 10-5-99

9. AGE last birthday 54 55 yrs — IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Cook

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Florida

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Deceased Unknown

14. MOTHER'S MAIDEN NAME: Deceased Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) Yes (If Yes, give war or dates of service) W W I and R.

16. SOCIAL SECURITY NO.

17. INFORMANT & ADDRESS: USNH Records

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

IMMEDIATE CAUSE (A) Cardiac Hypostasis without infarction (650 Emp) — INTERVAL BETWEEN ONSET AND DEATH: # 434.3 — UNDETERMINED

ANTECEDENT CAUSE (S) DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.

(B) Subdural Hematoma, left, old. # 331 DUE TO Congestion of the Liver — UNDETERMINED

(C) Ascetes

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☒ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY M.

21E. INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from DOA ..., 19 ..., to ..., 19 ..., that I last saw the deceased alive on ..., 19 ..., and that death occurred at M, from the causes and on the date stated above.

SIGNATURE George E. Hinsdale M.D. ADDRESS USNH Annapolis Md. DATE SIGNED 10-28-54

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial — DATE THEREOF 10-25-54 — NAME OF CEMETERY OR CREMATORY Annapolis Natl. — LOCATION (City, town, or county) Annapolis, Md. (State)

DATE REC'D BY LOCAL REGISTRAR — REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR — ADDRESS William Gene & Son 108 N. Washington St. Annapolis, Md.

VS. A15 — 10 - 53

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

09025

09006

MARYLAND

STATE DEPARTMETT OF HEALTH

CERTIFICATE OF DEATH

Reg. Dist. No. 28

MARGIN RESERVED FOR BINDING

1

1. PLACE OF DEATH: COUNTY Anne Arundel — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Crownsville — LENGTH OF STAY (In this place) 6yrs. 1mo.
HOSPITAL OR INSTITUTION OR STREET ADDRESS Crownsville State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland — COUNTY Charles
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Pomonkey
STREET ADDRESS (If rural, give location) None listed

3. NAME OF DECEASED (Type or Print): (First) Robert (Middle) G. (Last) Chase

4. DATE OF DEATH: (Month) 10 (Day) 12 (Year) 1954

5. SEX: Male

6. COLOR OR RACE: Negro

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): Single

8. DATE OF BIRTH: 10/6/96

9. AGE last birthday: 58 yrs. If under 1 year: Months. — Days — If under 24 hrs.: Hours — Min. —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farm Worker

10b. KIND OF BUSINESS OR INDUSTRY: Farm

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME: George Chase

14. MOTHER'S MAIDEN NAME: Mary Brown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Unk. (If year, give war or dates of service): Unk.

16. SOCIAL SECURITY No.: Unk.

17. INFORMANT AND ADDRESS: Hospital Records

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Pulmonary edema — Interval between onset and death: Known to us since 10-3-54

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Acute myocardial infarction — Known to us since 10-7-54

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: - - - -

19b. MAJOR FINDINGS OF OPERATION: - - - - - - - -

20. AUTOPSY? Yes ☒ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify): - - - - -

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY: - - - - -

(CITY OR TOWN) (COUNTY) (STATE): - - - - - - - - - - - -

TIME OF INJURY (Month) (Day) (Year) (Hour): - - - - - - m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR? - - - - - - - - - - - - - - -

22. I hereby certify that I attended the deceased from 6/28/ 10/12 1951, to 10/12 54, 1954, that I last saw the deceased alive on 10/12 54, 1954, and that death occurred at 5:35 a. m., from the causes and on the date stated above.

SIGNATURE Stanley C. Sargeant (Degree or title) — ADDRESS Crownsville, Md. — DATE SIGNED 10/12/54

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE Oct. 16 1954 — NAME OF CEMETERY OR CREMATORY St. Catherines — LOCATION (City, town, or county) Mc Conchie Md. (State)

DATE REC'D BY LOCAL REG. 10/14/54 — REGISTRAR'S SIGNATURE Jodie H Veney, Katherine M. Boyce

24. FUNERAL DIRECTOR: Hunt & Ryon — ADDRESS Waldorf Md.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09026

CERTIFICATE OF DEATH

Reg. Dist. No. 09007

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

1. PLACE OF DEATH:
COUNTY Anne Arundel — MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Odenton — LENGTH OF STAY (in this place) 4 mos.
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE — COUNTY
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington D. C.
STREET ADDRESS (If rural give location) 2605 Monroe N. E.

3. NAME OF DECEASED: (Type or Print) (First) Miriam (Middle) Bishop (Last) Clarke

4. DATE OF DEATH: (Month) 10 (Day) 20 (Year) 1954

5. SEX: F

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): Widow

8. DATE OF BIRTH. 9/4/1874

9. AGE last birthday 80 yrs. IF UNDER 1 YEAR Months 1 Days 16 IF UNDER 24 HRS. Hours 16 Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Centerville Md

12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME: John Hays Bishop

14. MOTHER'S MAIDEN NAME: Alice Dixon

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO. None

17. INFORMANT & ADDRESS: Mrs F. C. Adopt Odenton Md

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

1547 IMMEDIATE CAUSE — (A) Carcinoma Rectum — INTERVAL BETWEEN ONSET AND DEATH 1 yr.

ANTECEDENT CAUSE (S)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.

(B) DUE TO —

(C) —

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Rectal Hemorrhage Generalized Arteriosclerosis — 1 year

19A. DATE OF OPERATION: —

19B. MAJOR FINDINGS OF OPERATION —

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.

21E. INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Oct 19-54, 19 to Oct 20-, 54, that I last saw the deceased alive on Oct 20- 54, 19, and that death occurred at 3P. M, from the causes and on the date stated above.

SIGNATURE Wm. H. Lipskey — M. D. ADDRESS Odenton Md DATE SIGNED Oct 20-54

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial — DATE THEREOF 10/23/54 — NAME OF CEMETERY OR CREMATORY Petersville — LOCATION (City, town, or county) (State) Petersville, Md.

DATE REC'D BY LOCAL REGISTRAR Oct. 22, 1954 — REGISTRAR'S SIGNATURE Liliana Koslich

24. FUNERAL DIRECTOR ADDRESS Mallow Funeral Home, Inc 3200—Rhode Island Ave Brentwood, Md.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 09008

09027 CERTIFICATE OF DEATH Reg. Dist. No. 2

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
COUNTY Anne Arundel
CITY (If outside corporate limits, write RURAL OR TOWN and give nearest town) Harundale, Glen Burnie P.O.
HOSPITAL OR INSTITUTION OR STREET ADDRESS 806 Dale Rd
MARYLAND LENGTH OF STAY (in this place) 34 Yrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Anne Arundel
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Harundale, Glen Burnie, P.O.
STREET ADDRESS (Rural give location) 806 Dale Rd

3. NAME OF DECEASED: (Type or Print) (First) Rose (Middle) Agnes (Last) Couch

4. DATE OF DEATH: (Month) Oct. (Day) 21 (Year) 1954

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed

8. DATE OF BIRTH: Feb 20, 1893

9. AGE Last birthday: 61 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: John Rainey

14. MOTHER'S MAIDEN NAME: Annie Kaimers

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 212-12-6897

17. INFORMANT & ADDRESS: Grace Monks 504 Kent Rd Glen Burnie, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Congesting Heart Failure — Interval Between Onset And Death: 72 Hrs

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.
DUE TO (b) Diabetes Mellitus — 10 Yrs
DUE TO (c) Obesity — 20 Yrs

II OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. None

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT SUICIDE HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8/10, 1954 to 10/20, 1954, that I last saw the deceased alive on 10/20, 1954, and that death occurred at 8 A.M., from the causes and on the date stated above.

SIGNATURE (Degree or title) R.W. Richard M.D. ADDRESS 715 Cotter Rd Glen Burnie Md DATE SIGNED

23. BURIAL, CREMATION, REMOVAL: (Specify) B. DATE THEREOF 10.25.54 NAME OF CEMETERY OR CREMATORY Cedar Hill LOCATION (City, town, or county) (State) Balto.

DATE REC'D BY LOCAL REGISTRAR 10-27 REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR J. L. Sullivan ADDRESS 130 E. Fort Ave.

VS. A15

08937

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Reg. Dist. 09009

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15A - 5 - 53

1. PLACE OF DEATH:

COUNTY ANNE ARUNDEL — MARYLAND

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN ANNAPOLIS, MD.

LENGTH OF STAY (in this place)

HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE MD. COUNTY HOWARD

CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN Ellicott City

STREET ADDRESS (If rural, give location) COLUMBIA ROAD.

3. NAME OF DECEASED: (Type or Print) (First) Clyde (Middle) R. (Last) Dasher

4. DATE OF DEATH (Month) Oct. (Day) 23 (Year) 1954

5. SEX	6. COLOR OR RACE	7. ~~SINGLE~~, MARRIED, ~~WIDOWED~~, ~~DIVORCED~~. (Specify):	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
M	W		8/6/1905	49 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
CARPENTER	House Building	Fort Sybert, W.Va.	U.S.A.

13. FATHER'S NAME: Joseph Lloy Dasher

14. MOTHER'S MAIDEN NAME: Blanche Pope

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)	(If Yes, give war or dates of service)	16. SOCIAL SECURITY No.:	17. INFORMANT & ADDRESS:
NO			Mrs. Ada Dasher, Ellicott City, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Drowning — Sudden.

DUE TO

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (b) DUE TO

(c)

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION:	19b. MAJOR FINDING OF OPERATION:	20. AUTOPSY? Yes ☐ No ☒

21a. EXTERNAL CAUSE WAS PRIMARY ☑ or CONTRIBUTING ☐ CAUSE OF DEATH.	21b. PLACE (Home, farm, factory, OF street, office bldg., etc.) INJURY Severn River	21c. (City or town) (County) (State)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED While at work ☐ Not while at work ☑	21f. HOW DID INJURY OCCUR?
10 23 54 7 M.		Accident of boat while Harley water

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☐, and find that death resulted from: Natural causes ☐, Accident ☑, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE [signature] M. D.

CHIEF MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAM. ☐

DATE SIGNED 10/30/54

23. BURIAL, ~~CREMATION~~, ~~REMOVAL~~ (Specify):	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
	10/30/54	Good Shepherd	Ellicott City Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Oct. 30, 1954	[signature]	F.C. Higgin Bothom	Ellicott City, Md.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09028 **CERTIFICATE OF DEATH** 09010

Reg. Dist. No. 27

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15—10-53

1. PLACE OF DEATH:
COUNTY Anne Arundel — MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Barberville
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Fort George G. Meade, U.S.Army Hospital, DCA

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Virginia COUNTY Unknown
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Wyattsville
STREET ADDRESS (If rural give location) Box 441

3. NAME OF DECEASED: (Type or Print) (First) Hatcher (Middle) Charles (Last) Davidson

4. DATE OF DEATH: (Month) October (Day) 29 (Year) 1954

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): Married

8. DATE OF BIRTH: 28 June 1918

9. AGE last birthday: 36 yrs. IF UNDER 1 YEAR: Months / Days. IF UNDER 24 HRS.: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Soldier

10B. KIND OF BUSINESS OR INDUSTRY: U. S. ARMY

11. BIRTHPLACE (State or foreign country): Wyattsville, Va.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Grover C. Davidson

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S ARMED FORCES? (Yes, no, or unk.) Yes (If Yes, give war or dates of service) 17 years

16. SOCIAL SECURITY NO. unknown

17. INFORMANT & ADDRESS: U.S.Army Service records

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

IMMEDIATE CAUSE (A) Shock — INTERVAL BETWEEN ONSET AND DEATH: unknown

ANTECEDENT CAUSE (B) DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.

(B) Acute blood loss — unknown

DUE TO

(C) Compound, comminuted fracture left tibia, — unknown

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE OISEASE OR CONOITION CAUSING OEATH. possible head injury.

19A. DATE OF OPERATION:

19B. MAJOR FINOINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) Street

21C. WHERE DID INJURY OCCUR? (City or town) Barberville, (County) Anne Arundel, (State) Md.

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) 29 Oct 54 7 PM

21E. INJURY OCCURRED While at work ☐ Not while at work ☒

21F. HOW DID INJURY OCCUR? Struck by automobile

22. I hereby certify that I attended the deceased from DCA, 19 .., to .., 19 .., that I last saw the deceased alive on .. 19 .., and that death occurred at M, from the causes and on the date stated above.

SIGNATURE Robert Moore
ROBERT MOORE, CAPT., MC
ADDRESS M.O Ft GG Meade, Md.
DATE SIGNED 29 Oct 54

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial
DATE THEREOF 2 Nov 54
NAME OF CEMETERY OR CREMATORY Arlington National
LOCATION (City, town, or county) (State) Arlington, Virginia

DATE REC'O BY LOCAL REGISTRAR 1 Nov 54
REGISTRAR'S SIGNATURE T. A. Green CWO, C.E., USA

24. FUNERAL DIRECTOR AOORESS WM. COOK., BALTO., MD.

09029

09011

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Reg. Dist.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. .....

PLEASE WRITE PLAINLY, WITH UNFADING INK: Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15A - 5 - 53

1. PLACE OF DEATH:

COUNTY ANNE ARUNDEL — MARYLAND

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN rural Drury

LENGTH OF STAY (In this place)

HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE MD. COUNTY ANNE ARUNDEL

CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN Drury

STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED: (Type or Print) (First) MARTHA (Middle) (Last) DAVIS

4. DATE OF DEATH (Month) Oct. (Day) 31, (Year) 1954

5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR: Months	Days	IF UNDER 24 HRS.: Hours	Min.
female	colored	Married	May 1, 1917	37 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired):	10b. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country):	12. CITIZEN OF WHAT COUNTRY?
Maid		Drury Md.	

13. FATHER'S NAME: Ahron Johnson

14. MOTHER'S MAIDEN NAME: Louise Chase

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)	16. SOCIAL SECURITY NO.:	17. INFORMANT & ADDRESS:
		Thomas Davis Drury , Maryland

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

Immediate cause (a) Massive hemoperitoneum — DUE TO

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (b) Rupture of ectopic pregnancy, right tube — DUE TO

(c)

INTERVAL BETWEEN ONSET AND DEATH

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION:	19b. MAJOR FINDING OF OPERATION:	20. AUTOPSY? Yes ☒ No ☐

21a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.	21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY	21c. (City or town) (County) (State)

21d. TIME (Month) (Day) (Year) (Hour) OF INJURY M.	21e. INJURY OCCURRED While at work ☐ Not while at work ☐	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE R K Fisher M. D.

CHIEF MEDICAL EXAMINER ☒
DEPUTY MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAM. ☐

DATE SIGNED Nov. 1, 1954

23. BURIAL, ~~CREMATION~~, ~~REMOVAL~~ (Specify):	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	11-4-54	Moses Cemetery	Anne Arundel Co. Md

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
11/2/54	A. W. Hedrick	John T. Stewart	30 H St. N.E. Wash. D.C.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 09012

CERTIFICATE OF DEATH

09030

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: Please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH:
COUNTY: Anne Arundel
CITY (If outside corporate limits, write RURAL) OR TOWN and give nearest town): Roland Terrace
LENGTH OF STAY (in this place): 6 weeks
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 5720 Franklin St.

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE: Maryland
COUNTY:
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Baltimore
STREET ADDRESS (If rural give location): 707 Cedarcroft Road.

3. NAME OF DECEASED: (Type or Print) (First) (Middle) (Last): William Frank Downey Sr.

4. DATE OF DEATH: (Month) (Day) (Year): Oct. 6th. 1954

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: I/27/78

9. AGE last birthday: 76 yrs. IF UNDER 1 YEAR: Months, Days; IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired: Bookeeper

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Rock Hall, Maryland.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: William Thomas Downey

14. MOTHER'S MAIDEN NAME: Ella Ayres

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): No
(If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 215-07-9479

17. INFORMANT & ADDRESS: Mrs. Margaret Downey, (wife).

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset And Death
Immediate cause	(a) Cerebral Hemorrhage	6 hrs.
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.	DUE TO (b) General Arteriosclerosis	5 y.
	DUE TO (c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8/23/54 19 .., to 10/6/54 ....., 19 ., that I last saw the deceased alive on 10/1/54 ., 19 .., and that death occurred at 5.30 P.M., from the causes and on the date stated above.

SIGNATURE (Degree or title): Eustace K. Faulkerson M.D. ADDRESS: Glen Burnie, Md. DATE SIGNED: 10/7/54

23. BURIAL, CREMATION, REMOVAL (Specify): Burial

DATE THEREOF: 10/9/54

NAME OF CEMETERY OR CREMATORY: Moreland Memorial Park, Baltimore County, Md.

LOCATION (City, town, or county) (State)

DATE REC'D BY LOCAL REGISTRAR: 10-8-54

REGISTRAR'S SIGNATURE: A. W. Hedrick

24. FUNERAL DIRECTOR ADDRESS: Burgee Funeral Home, 3631 Falls Rd. Baltimore, MD.

Horace F. Burgee

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 09013

09031 CERTIFICATE OF DEATH

Reg. Dist. No. ..

1. PLACE OF DEATH:
COUNTY Anne Arundel MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville
LENGTH OF STAY (In this place) 4 mos. 13 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS Crownsville State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: WC
STATE Maryland COUNTY Baltimore City
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore City
STREET ADDRESS (If rural give location) 1437 W. Lanvale Street

3. NAME OF DECEASED: (Type or Print) (First) Mamie (Middle) (Last) Evans

4. DATE OF DEATH: (Month) 10 (Day) 1 (Year) 19 54

5. SEX: Female
6. COLOR OR RACE: Negro
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widow
8. DATE OF BIRTH: 2/2/02
9. AGE last birthday 52 yrs.
IF UNDER 1 YEAR: Months — Days —
IF UNDER 24 HRS.: Hours — Min. —

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Unemployed
10B. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): North Carolina
12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME: Joseph Allen
14. MOTHER'S MAIDEN NAME: Mary White

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) Unk. (If Yes, give war or dates of service) Unk.
16. SOCIAL SECURITY NO. Unk.
17. INFORMANT & ADDRESS: Hospital Records

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

IMMEDIATE CAUSE (A) Chronic Myocarditis — INTERVAL BETWEEN ONSET AND DEATH: Known to us since 5/18/54

ANTECEDENT CAUSE (S) DUE TO (B) Hypertensive Cardiovascular Disease — "

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Involutional Psychosis — "

19A. DATE OF OPERATION: — — — —
19B. MAJOR FINDINGS OF OPERATION — — — — — — — —
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) — — — — — —
21C. WHERE DID INJURY OCCUR? (City or town) (County) (State) — — — — — — — — — — — — — — —
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) — — — — — — — M.
21E. INJURY OCCURRED While at work ☐ Not while at work ☐
21F. HOW DID INJURY OCCUR? — — — — — — — — — — — — — — —

22. I hereby certify that I attended the deceased from 5/18, 19 54 to 10/1, 19 54 that I last saw the deceased alive on 10/1, 19 54, and that death occurred at 2:20a. M, from the causes and on the date stated above.

SIGNATURE & Tekben E. Kramer M. D. ADDRESS Crownsville, Md. DATE SIGNED 10/1/54

23. BURIAL, CREMATION, REMOVAL (Specify) Burial
DATE THEREOF Oct. 2, 1954
NAME OF CEMETERY OR CREMATORY Family lot
LOCATION (City, town, or county) (State) New York, N. Y.

DATE REC'D BY LOCAL REGISTRAR
REGISTRAR'S SIGNATURE
24. FUNERAL DIRECTOR Frederick Funeral Home ADDRESS 631 Druid Hill Ave.

VS. A15—10-52

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 09014

08998 CERTIFICATE OF DEATH Reg. Dist. No. .....

1. PLACE OF DEATH:
COUNTY Carroll MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Carrollton Md.
LENGTH OF STAY (In this place) 3 mo
HOSPITAL OR INSTITUTION OR STREET ADDRESS 1312 West St

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Ca
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Elm Towne Md
STREET ADDRESS (If rural give location) 800 Dale Road

3. NAME OF DECEASED: (Type or Print) (First) Clara (Middle) L (Last) Fleckenstein
4. DATE OF DEATH: (Month) Oct. (Day) 29 (Year) 1954
5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married
8. DATE OF BIRTH: Oct 18-1880
9. AGE last birthday: 74 yrs.
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): House Work
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Grand Rapids Mich
12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: Edgar L Wright
14. MOTHER'S MAIDEN NAME: Margaret V Kilpatrick
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) no
16. SOCIAL SECURITY No.: None
17. INFORMANT & ADDRESS: Mrs Augusta Bryan 800 Dale Rd Hampstead Md

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH
Immediate cause (a) Coronary Thrombosis
Antecedent causes (s) Diseases or conditions, If any, giving rise to the above cause stating the underlying cause last. DUE TO (b) Arteriosclerotic Heart Disease
DUE TO (c)
Interval Between Onset And Death: (a) 1 day (b) 5 yrs.

11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURED While at Work ☐ Not While At Work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Oct 1, 1954, to Oct 29, 1954, that I last saw the deceased alive on 10-19-1954, and that death occurred at 1:00 AM, from the causes and on the date stated above.
SIGNATURE James L Martin (Degree or title) M D
ADDRESS Glenwood Md
DATE SIGNED 10-30-54

23. BURIAL, CREMATION, REMOVAL (Specify) Burial
DATE THEREOF Oct 22-54
NAME OF CEMETERY OR CREMATORY Elm Haven
LOCATION (City, town, or county) (State) C C Co Md

DATE REC'D BY LOCAL REGISTRAR Oct 21 1954
REGISTRAR'S SIGNATURE Wm. J. French
24. FUNERAL DIRECTOR Bernard A Funk
ADDRESS Elm Towne Md
L J D'Alba md

VS. A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

09015

09032

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 22

M

1

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY ANNE ARUNDEL; MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN JESSUP; LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS MARYLAND HOUSE of CORRECTION

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE NEW YORK; COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN KATONAH
STREET ADDRESS (If rural, give location) KATONAH N.Y

3. NAME OF DECEASED (Type or Print): (First) PATRICK (Middle) R. (Last) FOLEY

4. DATE OF DEATH: (Month) OCT (Day) 2 (Year) 19 54

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): DIVORCED

8. DATE OF BIRTH: Oct 22 1907

9. AGE last birthday: 47 yrs.

If under 1 year: Months; Days; If under 24 hrs.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): CONSTRUCTION

10b. KIND OF BUSINESS OR INDUSTRY: ENGINEER

11. BIRTHPLACE (State or foreign country): NEW YORK STATE

12. CITIZEN OF WHAT COUNTRY? U.S.A

13. FATHER'S NAME: PATRICK FOLEY

14. MOTHER'S MAIDEN NAME: JULIA M ROBISON

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY No. 073-15-2614

17. INFORMANT AND ADDRESS: MRS. Robt Palmer, BREWSTER NY

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Hepatitis, acute, infectious (virus) — Interval Between Onset and Death: 1 month

12X Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 9-10, 1954, to 10-2, 1954, that I last saw the deceased alive on 10-2, 1954, and that death occurred at 4:15 P.M., from the causes and on the date stated above.

SIGNATURE (Degree or title): Robert B Taylor MD ADDRESS: Jessup Md Maryland House of Correction DATE SIGNED: 10-2-54

23. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

DATE THEREOF: 10-7-54

NAME OF CEMETERY OR CREMATORY: CALVERY

LOCATION (City, town, or county) (State): White Plains NY

DATE REC'D BY LOCAL REG. Oct 2-54

REGISTRAR'S SIGNATURE: Clara Haslup

24. FUNERAL DIRECTOR: Hubbard ADDRESS: 4101 White Plains Ave Bronx 13 NY

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 09016

09033

CERTIFICATE OF DEATH

Reg. Dist. No. 28

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL) OR TOWN and give nearest town) Crownsville
LENGTH OF STAY (in this place) 2 yrs 10 mos
HOSPITAL OR INSTITUTION OR STREET ADDRESS Crownsville State Hosp

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Calvert
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Owings, Calvert County
STREET ADDRESS (If rural give location)

3. NAME OF DECEASED: (Type or Print) (First) Maggie (Middle) (Last) Freeland

4. DATE OF DEATH: (Month) 10 (Day) 4 (Year) 1954

5. SEX: F

6. COLOR OR RACE: Negro

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed

8. DATE OF BIRTH: 1881

9. AGE last birthday: 72 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Rural School Teacher

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: ?

14. MOTHER'S MAIDEN NAME: Maggie Macon

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) no (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT & ADDRESS: Hospital records

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Broncho, pneumonia. — Interval Between Onset And Death

DUE TO

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b)

DUE TO

(c)

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Generalized Arteriosclerosis

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 11/29, 1951, to 10-4, 1954, that I last saw the deceased alive on 10-4, 1954, and that death occurred at 3:05 p.m., from the causes and on the date stated above.

SIGNATURE Arnold H. Sibert M.D. (Degree or title) ADDRESS DATE SIGNED 10-4-54

23. BURIAL, CREMATION, REMOVAL (Specify) DATE THEREOF 10-7-54 NAME OF CEMETERY OR CREMATORY Plummer Point LOCATION (City, town, or county) Calvert Co. (State) Md.

DATE REC'D BY LOCAL REGISTRAR 10-4-54 REGISTRAR'S SIGNATURE K M Deem

24. FUNERAL DIRECTOR P. E. Sewell Prince Frederick ADDRESS Md

VS. A15

09034 MARYLAND STATE DEPARTMENT OF HEALTH 09017

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 21

Item 8, Filed 172 11-1-54 et

1. PLACE OF DEATH: COUNTY Anne Arundel Co., MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis R.F.D. | LENGTH OF STAY (in this place) 6 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS Anne Arundel General Annapolis Md.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY A.A. Co.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Woodland Beach, Edgewater Md
STREET ADDRESS (If rural, give location) Beach Drive

3. NAME OF DECEASED (Type or Print): (First) Carmen (Middle) G. (Last) Frost

4. DATE OF DEATH: (Month) Oct. (Day) 26 (Year) 1954

5. SEX: White | 6. COLOR OR RACE: White | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married | 8. DATE OF BIRTH: Jan 19-1901 | 9. AGE last birthday: 50 yrs. | If under 1 year: Months, Days | If under 24 hrs.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Self Employed | 10b. KIND OF BUSINESS OR INDUSTRY: Dry Cleaning | 11. BIRTHPLACE (State or foreign country): Washington DC | 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Edward H. Frost | 14. MOTHER'S MAIDEN NAME: Elizabeth Burke

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT AND ADDRESS: Mrs Eva Frost Woodland Beach A.A. Co. Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Coronary Thrombosis 6 days

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last
(b) Myocardial Infarction
(c) Hypertension acute 6 days

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Diabetic Mellitus unknown

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Oct 21, 1954, to Oct 26, 1954, that I last saw the deceased alive on Oct 26, 1954, and that death occurred at 1:30 p.m., from the causes and on the date stated above.

SIGNATURE: George C. Beil (Degree or title) M.D. ADDRESS Annapolis Md DATE SIGNED 10-26-54

23. BURIAL, CREMATION, REMOVAL (Specify) Removal | DATE THEREOF 10/26/54 | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) (State) Washington D.C.

DATE REC'D BY LOCAL REG. Oct. 26, 1954 | REGISTRAR'S SIGNATURE [illegible] | 24. FUNERAL DIRECTOR ADDRESS Robert A. Mattingly 131-11th St. S.E. Wash. D.C.

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09035 CERTIFICATE OF DEATH

Reg. Dist. No. 09018

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH:
COUNTY A.A. County — MARYLAND
CITY (If outside corporate limits, write RURAL) OR TOWN and give nearest town: Pasedena
LENGTH OF STAY (in this place): Life
HOSPITAL OR INSTITUTION OR STREET ADDRESS:

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland — COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Pasedena Md
STREET ADDRESS (If rural give location):

3. NAME OF DECEASED: (First) Carrie (Middle) Rebbeca (Last) Green

4. DATE OF DEATH: (Month) 10 (Day) 28 (Year) 1954

5. SEX: Female — 6. COLOR OR RACE: Colored

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: 7-20-1894

9. AGE last birthday: 60 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): House Wife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Pasedena Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Elija Thomas Brown

14. MOTHER'S MAIDEN NAME: Elizebeth Too good

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): 4 — (If Yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT & ADDRESS: Garrison Green Pasedena Md.

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Congestive Heart Failure — Interval Between Onset And Death: 4 Months

DUE TO

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.

(b) Hypertension — 3 years

DUE TO

(c)

11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death: none

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Oct. 16, 1954, to Oct. 28, 1954, that I last saw the deceased alive on Oct. 28, 1954, and that death occurred at 12:45 P.M., from the causes and on the date stated above.

SIGNATURE (Degree or title): R. M. McLaughlin M.D.

ADDRESS: Pasadena. Md.

DATE SIGNED: Octber 28, 1954

23. BURIAL, CREMATION, REMOVAL (Specify): Burial

DATE THEREOF: Oct. 31, 1954

NAME OF CEMETERY OR CREMATORY: Magothy Farm

LOCATION (City, town, or county) (State): Pasedena Md.

DATE REC'D BY LOCAL REGISTRAR: 10/29/54

REGISTRAR'S SIGNATURE: Ida Hadud Deputy

24. FUNERAL DIRECTOR: Wm. G. Jackson Funeral Home Inc.

ADDRESS: 916 Penna. Ave.

09036

09019

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Item 7, FilmG172 11-5-54 et

Reg. Dist. No. .....

MARGIN RESERVED FOR BINDING

USE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

1. PLACE OF DEATH: COUNTY Anne Arundel — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Brooklyn Park, Md. | LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Brooklyn Park, Maryland

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland — COUNTY Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore
STREET ADDRESS (If rural, give location) 406 East 22½ Street

3. NAME OF DECEASED (Type or Print): (First) PETER (Middle) (Last) GREEN
4. DATE OF DEATH: (Month) Oct. (Day) 26 (Year) 1954

5. SEX: Male
6. COLOR OR RACE: Colored
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single
8. DATE OF BIRTH:
9. AGE last birthday: 31 yrs. | If under 1 year: Months / Days | If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): X
10b. KIND OF BUSINESS OR INDUSTRY: X
11. BIRTHPLACE (State or foreign country): N C
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: —
14. MOTHER'S MAIDEN NAME: —

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT AND ADDRESS: John Benson 406 E 22½ Street

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Accidental drowning.

Antecedent cause(s) Disease or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY X OR CONTRIBUTING CAUSE OF DEATH. | PLACE (Home, farm, factory, street, office bldg., etc.) INJURY Gravel Pit | (CITY OR TOWN) Brooklyn Park | (COUNTY) Anne Arundel | (STATE) Md.

TIME OF INJURY (Month) (Day) (Year) (Hour) Oct. 26, 1954 p.m. | INJURY OCCURRED While at work ☐ Not while at work ☒ | HOW DID INJURY OCCUR? Shot down a bird, plunged in water to get it.

22 *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection X, Inquiry X thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident X, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

R S Fisher Chief Medical Examiner 700 Fleet St. Oct. 27, 1954

23. BURIAL, CREMATION, REMOVAL (Specify) Burial | DATE THEREOF Nov 2 54 | NAME OF CEMETERY OR CREMATORY Mt Carmel | LOCATION (City, town, or county) A A Co Md (State)

DATE REC'D BY LOCAL REG. 11/2/54 | REGISTRAR'S SIGNATURE A. W. Hedrick | 24. FUNERAL DIRECTOR Joana L Brown Son ADDRESS 10 W County Comm St

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 09020

09037 **CERTIFICATE OF DEATH** Reg. Dist. No. 28

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15—10-53

1. PLACE OF DEATH.
COUNTY Anne Arundel MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville
LENGTH OF STAY (in this place) 8 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS Crownsville State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Baltimore City
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore City
STREET ADDRESS (If rural give location)

3. NAME OF DECEASED: (Type or Print) (First) James (Middle) (Last) Grimes

4. DATE OF DEATH: (Month) 10 (Day) 1 (Year) 1954

5. SEX: Male

6. COLOR OR RACE: Negro

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Unk.

8. DATE OF BIRTH: 1911?

9. AGE last birthday 43? yrs. IF UNDER 1 YEAR Months — Days — IF UNDER 24 HRS. Hours — Min. —

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Unk.

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Unk.

12. CITIZEN OF WHAT COUNTRY? Unk.

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) Unk. (If Yes, give war or dates of service) Unk.

16. SOCIAL SECURITY NO. Unk.

17. INFORMANT & ADDRESS: Hospital Records

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

IMMEDIATE CAUSE (A) Pulmonary Edema

ANTECEDENT CAUSE (S) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST

OUE TO (B) Myocardial Disease

OUE TO (C)

INTERVAL BETWEEN ONSET AND DEATH

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE OEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. General Paresis, Generalized Arteriosclerosis

19A. DATE OF OPERATION: — — — — —

19B. MAJOR FINDINGS OF OPERATION — — — — — — — — — — — — — — — —

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) — — — — — — — M.

21E. INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR? — — — — — — — — — — — — — — —

22. I hereby certify that I attended the deceased from . . . . . , 19 . ., to . . . . . , 19 ., that I last saw the deceased alive on . . . . . , 19 . . . . , and that ~~death~~ occurred at 4:35 A M, from the causes and on the date stated above.

SIGNATURE [signature] M. D. ADDRESS Crownsville, Md. DATE SIGNED 10/1/54

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial DATE THEREOF 10-4-54 NAME OF CEMETERY OR CREMATORY W. T. Albrun Cemetery LOCATION (City, town, or county) (State) Balto. Md.

DATE REC'D BY LOCAL REGISTRAR 10-4-54 REGISTRAR'S SIGNATURE [signature]

24. FUNERAL DIRECTOR Adolphus Halstead ADDRESS 2118 Druid Hill ave.

08999

MARYLAND

STATE DEPARTMETT OF HEALTH

CERTIFICATE OF DEATH

Reg. Dist. No. 21 09021

1. PLACE OF DEATH
COUNTY A. A. — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS G. H. General

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE Md. COUNTY A A
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
STREET ADDRESS (If rural, give location) 20 Smithgate Ave

3. NAME OF DECEASED (Type or Print): (First) Emma (Middle) Irene (Last) Grimm
4. DATE OF DEATH: (Month) 10 (Day) 18 (Year) 1954
5. SEX: F.
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)
8. DATE OF BIRTH: 9-28-1906
9. AGE last birthday: 48 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Clerk
10b. KIND OF BUSINESS OR INDUSTRY: U. S. P. Store
11. BIRTHPLACE (State or foreign country): Baltimore Md.
12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME: Reginal V. Hornberger
14. MOTHER'S MAIDEN NAME: Emma V. Jerschied
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)
16. SOCIAL SECURITY No. 215-24-3901
17. INFORMANT AND ADDRESS: Mrs Richard D. Dowell (2)

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

1954

Immediate cause (a) adenocarcinoma of ovary — 7 months

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) with metastases in abdomen

(c) Rectal cancer, intestinal obstruction

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY | (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from ....., 19..., to 10-18., 1954, that I last saw the deceased alive on 10-18., 1954, and that death occurred at 10 AM m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED 10/19/54

23. BURIAL, ~~CREMATION~~ REMOVAL (Specify) | DATE 10-21-54 | NAME OF CEMETERY OR CREMATORY Cedar Bluff | LOCATION (City, town, or county) Annapolis (State) Md

DATE REC'D BY LOCAL REG. 10/19/54 | REGISTRAR'S SIGNATURE | 24. FUNERAL DIRECTOR John M. Taylor & Sons ADDRESS Annapolis Md

MARGIN RESERVED FOR BINDING

02038

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09022 Reg. Dist.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 26

1. PLACE OF DEATH:
COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural - Tracy's Landing
LENGTH OF STAY (in this place) life
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md. COUNTY Anne Arundel
CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN Rural Tracy's Landing
STREET ADDRESS (If rural, give location) Rout 255 - Nutwell Area

3. NAME OF DECEASED: (Type or Print) (First) Peggy (Middle) Lee (Last) Gross

4. DATE OF DEATH (Month) (Day) (Year) October 18 1954

5. SEX: female

6. COLOR OR RACE: Negro

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single

8. DATE OF BIRTH: April 26 1954

9. AGE last birthday: yrs. 5 IF UNDER 1 YEAR: Months / Days IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired):

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Baltimore City

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Albert Gross

14. MOTHER'S MAIDEN NAME: Blondell Chapman

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) —

16. SOCIAL SECURITY NO.: —

17. INFORMANT & ADDRESS: Blondell C. Gross Nutwell, Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

Immediate cause (a) pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 3 days.

DUE TO

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (b) prematurity

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION:

19b. MAJOR FINDING OF OPERATION:

20. AUTOPSY? Yes ☐ No ☒

21a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

21b. PLACE (Home, farm, factory, OF street, office bldg., etc.) INJURY

21c. (City or town) (County) (State)

21d. TIME (Month) (Day) (Year) (Hour) OF INJURY M.

21e. INJURY OCCURRED While at work ☐ Not while at work ☐

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE Bowie Linn Grant M.D. M. D.

CHIEF MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAM. ☒

DATE SIGNED 10-19-54

23. BURIAL, CREMATION, REMOVAL (Specify): burial

DATE THEREOF Oct 21-54

NAME OF CEMETERY OR CREMATORY Carters Cemetery

LOCATION (City, town, or county) Friendship (State) Md

DATE REC'D BY LOCAL REG. Oct 19, 54

REGISTRAR'S SIGNATURE J. B. Dent

24. FUNERAL DIRECTOR Hardesty Funeral Home ADDRESS Md

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

VS. A15A - 5 - 53

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09039 **CERTIFICATE OF DEATH** Reg. Dist. No. 09023

1. PLACE OF DEATH:
COUNTY ANN ARUNDEL MARYLAND
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN RURAL, PASADENA
LENGTH OF STAY (in this place) LIFE
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE MARYLAND COUNTY A.A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN RURAL, PASADENA
STREET ADDRESS (If rural give location)

3. NAME OF DECEASED: (Type or Print) (First) MARY (Middle) ADELINE (Last) HANCOCK

4. DATE OF DEATH: (Month) 10 (Day) 27 (Year) 19 54

5. SEX: F

6. COLOR OR RACE: W

7. (SINGLE) MARRIED, WIDOWED, DIVORCED, (Specify):

8. DATE OF BIRTH: Jan 27 1869

9. AGE last birthday: 85 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): HOME MAKER

10b. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (State or foreign country): MARYLAND.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: HENRY A. HANCOCK

14. MOTHER'S MAIDEN NAME: MATILDA WILKINSON

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.: —

17. INFORMANT & ADDRESS: PANSY COOK (Niece)

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) INFLUENZA DUE TO

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) DUE TO

(c)

Interval Between Onset And Death: 1 week

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. ARTERIOSCLEROSIS, GENERALIZED — YEARS

19a. DATE OF OPERATION: None

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July 1, 19 54, to Oct 27, 19 54 that I last saw the deceased alive on Oct 26, 1954, and that death occurred at 10 AM, from the causes and on the date stated above.

SIGNATURE J. F. Palmisano (Degree or title) M.D. ADDRESS Mountain Rd, Pasadena, Md DATE SIGNED 10/27/54

23. BURIAL, CREMATION, REMOVAL. (Specify) Burial

DATE THEREOF October 29 1954

NAME OF CEMETERY OR CREMATORY Hancock Family Cemetery

LOCATION (City, town, or county) (State) Bayside Beach, A.A. Co. Md.

DATE REC'D BY LOCAL REGISTRAR October 29, 1954

REGISTRAR'S SIGNATURE L. J. D'Alba

24. FUNERAL DIRECTOR R. V. Singleton ADDRESS Glen Burnie, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A11

09040

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Reg. No. 09024

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. .....

1. PLACE OF DEATH:
COUNTY ANNE ARUNDEL MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Edmonds
LENGTH OF STAY (In this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Route 301 one-half mile south of Route 424

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE MARYLAND COUNTY
CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN BALTIMORE
STREET ADDRESS (If rural, give location) 516 W. HAMBURG ST.

3. NAME OF DECEASED: (First) SIDNEY (Middle) (Last) HARRIS, JR.

4. DATE OF DEATH (Month) October (Day) 18 (Year) 1954

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	Colored	MARRIED	MAR. 15, 1916	38 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): LABORER
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): NORTH CAROLINA
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: SIDNEY HARRIS
14. MOTHER'S MAIDEN NAME: ERMA COPPAGE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) YES (If Yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 240-14-3212
17. INFORMANT & ADDRESS: GLADYS HARRIS 218 ELORY STREET

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Skull fracture	
DUE TO		
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last	(b) Crushed chest	
DUE TO		
	(c)	

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION:	19b. MAJOR FINDING OF OPERATION:	20. AUTOPSY? Yes ☐ No ☒

21a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.	21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY highway	21c. (City or town) Anne Arundel (County)	(State) Maryland
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY Oct. 18, 1954 4 P.M.	21e. INJURY OCCURRED While at work ☒ Not while at work ☐	21f. HOW DID INJURY OCCUR? Passenger in truck-truck collision.	

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and find that death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE William V. Gooch M. D.
CHIEF MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAM. ☒
DATE SIGNED Oct. 22, 1954

23. BURIAL, CREMATION, REMOVAL (Specify):	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
BURIAL	10/28/54	COLEY	LITTLETON, N.C.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
10-26-54	A.W. Hedrich	CHARLES A. RICE	661 W. BARRE STREET

ik dmr.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A - 5 - 53

MARYLAND 09000

09025

STATE DEPARTMETT OF HEALTH

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH
COUNTY A. A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
MARYLAND LENGTH OF STAY (in this place) 0
HOSPITAL OR INSTITUTION OR STREET ADDRESS A. A. General

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE Md. COUNTY A. A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
STREET ADDRESS (If rural, give location) 315 Washington St.

3. NAME OF DECEASED (Type or Print) (First) Elizabeth (Middle) I (Last) Hatchel

4. DATE OF DEATH (Month) 10 (Day) 4 (Year) 19 54

5. SEX Female

6. COLOR OR RACE White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widow

8. DATE OF BIRTH 6-19-1879

9. AGE last birthday 75 yrs.
If under 1 year: Months | Days
If under 24 hrs.: Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nurse Wife

10b. KIND OF BUSINESS OR INDUSTRY Home

11. BIRTHPLACE (State or foreign country) Shadyside A A Co Md.

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME John R Lee

14. MOTHER'S MAIDEN NAME Mary E. Collinson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) —
(If year, give war or dates of service) —

16. SOCIAL SECURITY NO. —

17. INFORMANT AND ADDRESS Russell Hallock Annapolis Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Carcinoma Liver with obstruction — Interval Between Onset and Death: Several Months

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Jaundice

(c) Arteriosclerosis Hypertension with — Several years

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Generalized Arteriosclerosis

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Sept 15, 1954, to Oct 4, 1954, that I last saw the deceased alive on Oct 4, 1954, and that death occurred at 10 30 P.M., from the causes and on the date stated above.

SIGNATURE George C Boeil (Degree or title) M. D ADDRESS Annapolis Md DATE SIGNED 10-5-54

23. BURIAL, ~~CREMATION~~ REMOVAL (Specify) DATE 10-7-54

NAME OF CEMETERY OR CREMATORY Cedar Bluff

LOCATION (City, town, or county) Annapolis (State) Md

DATE REC'D BY LOCAL REG. Oct. 6, 1954

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR John M. Taylor & Son ADDRESS Annapolis Md

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 09026

09041 CERTIFICATE OF DEATH Reg. Dist. No. 28

1. PLACE OF DEATH:
COUNTY Anne Arundel MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville
LENGTH OF STAY (in this place) 1 yr. 4 mos.
HOSPITAL OR INSTITUTION OR STREET ADDRESS Crownsville State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Baltimore City
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore City
STREET ADDRESS (If rural give location) 822 McKean Avenue

3. NAME OF DECEASED: (Type or Print) (First) William (Middle) A (Last) Holliday

4. DATE OF DEATH: (Month) 10 (Day) 7 (Year) 1954

5. SEX: M

6. COLOR OR RACE: Negro

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): Widowed

8. DATE OF BIRTH: 11/8/1895

9. AGE last birthday: 58 yrs. IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS.: Hours — Min. —

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Unk.

10B. KIND OF BUSINESS OR INDUSTRY: Unk.

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) Unk. (If Yes, give war or dates of service) Unk.

16. SOCIAL SECURITY NO. 215-09-1673

17. INFORMANT & ADDRESS: Hospital Records & Undertaker

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

IMMEDIATE CAUSE (A) Hypertensive Cardiovascular Disease

ANTECEDENT CAUSE (S) DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO

(C)

INTERVAL BETWEEN ONSET AND DEATH: Known to us since 6/9/53

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION: - - - - -

19B. MAJOR FINDINGS OF OPERATION - - - - - - - - - - - - - - - - - -

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) - - - - - - - -

21C. WHERE DID INJURY OCCUR? (City or town), (County) (State) - - - - - - - - - - - - - - - - - -

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M. - - - - - -

21E. INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR? - - - - - - - - - - - - - - - - - -

22. I hereby certify that I attended the deceased from . . , 19 . . , to 10/7, 1954 that I last saw the deceased alive on 10/7, 1954, and that death occurred at 8:05p M, from the causes and on the date stated above.

SIGNATURE [signature] M. D. ADDRESS Crownsville, Md. DATE SIGNED 10/8/54

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial DATE THEREOF 10/11/54 NAME OF CEMETERY OR CREMATORY Arbutus Cem. LOCATION (City, town, or county) Baltimore County (State) Md

DATE REC'D BY LOCAL REGISTRAR 10-11-54 REGISTRAR'S SIGNATURE [signature] Deputy

24. FUNERAL DIRECTOR Charles Hoppe ADDRESS 512 Pennsylvania Ave

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15—10-52

09001 **MARYLAND STATE DEPARTMENT OF HEALTH** 09027

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 21

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH: COUNTY Anne Arundel; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis, Md.; LENGTH OF STAY (In this place) 6 yrs.; HOSPITAL OR INSTITUTION OR STREET ADDRESS 213 Norwood Road, Waterdown

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Anne Arundel; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis, Md.; STREET ADDRESS (If rural, give location) 212 Norwood Road, Waterdown

3. NAME OF DECEASED (Type or Print): (First) Edith (Middle) Gonzalez (Last) Hottel

4. DATE OF DEATH: (Month) 10 (Day) 19 (Year) 1954

5. SEX: Female

6. COLOR OR RACE: Caucasian

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: 8-8-06

9. AGE last birthday: 48 yrs. If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (State or foreign country): Galveston, Texas.

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Julian C. Gonzalez

14. MOTHER'S MAIDEN NAME: Emeline Davis

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. None

17. INFORMANT AND ADDRESS: Husband. 212 Norwood Rd. Waterdown

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Coronary Occlusion — Interval Between Onset and Death: 1 hr. 15 min.

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) —

(c) —

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. None Known

19a. DATE OF OPERATION —

19b. MAJOR FINDINGS OF OPERATION —

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) —

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — (CITY OR TOWN) — (COUNTY) — (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. —

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR? —

22. I hereby certify that I attended the deceased ~~from~~ on 10-19, 1954, to 2330 → 2350, 19....., that I ~~last saw~~ did not see the deceased alive on ....., 19....., and that death occurred at approximately 2330 10-19-54 m., from the causes and on the date stated above.

SIGNATURE: John J. Egan M.D. (Degree or title) LCdr (MC) USN ADDRESS USNH, Annapolis. DATE SIGNED 10-20-1954

23. BURIAL, CREMATION / REMOVAL (Specify): Cremation | DATE THEREOF 10-20-54 | NAME OF CEMETERY OR CREMATORY Ft Lincoln | LOCATION (City, town, or county) Prince Geo. Co (State) Md.

DATE REC'D BY LOCAL REG. 20 | REGISTRAR'S SIGNATURE [illegible]

24. FUNERAL DIRECTOR John M. Taylor-Sons ADDRESS Annapolis Md.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09002 **CERTIFICATE OF DEATH**

1:9028

Reg. Dist. No. 21

1. PLACE OF DEATH:
COUNTY Anne Arundel — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
LENGTH OF STAY (in this place) 10
HOSPITAL OR INSTITUTION OR STREET ADDRESS Anne Arundel General

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland — COUNTY A.A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
STREET ADDRESS (If rural give location) 3 Pleasant Court

3. NAME OF DECEASED: (Type or Print) (First) Blossie (Middle) R. (Last) Hunt

4. DATE OF DEATH: (Month) Oct., (Day) 16, (Year) 1954

5. SEX: Female

6. COLOR OR RACE: Colored

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: March 12, 1906

9. AGE last birthday: 48 yrs. IF UNDER 1 YEAR: Months 7, Days 16 — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): Domestic

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Annapolis, Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: William Matthews

14. MOTHER'S MAIDEN NAME: Isbella Matthews

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

16. SOCIAL SECURITY No.:

17. INFORMANT & ADDRESS: James Hunt, Annapolis, Md.

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Cerebral Hemorrhage — Interval Between Onset And Death: 10 hrs.

DUE TO

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.

(b) Rt hemiplegia

DUE TO

(c) Hypertension — unknown

11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Oct 15, 1954, to Oct 16, 1954, that I last saw the deceased alive on Oct 16, 1954, and that death occurred at 2 A.M., from the causes and on the date stated above.

SIGNATURE (Degree or title): George C Bosl M.D. — ADDRESS: Annapolis, Md. — DATE SIGNED: 10-18-54

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE THEREOF: Oct 20, 1954 — NAME OF CEMETERY OR CREMATORY: Brewer Hill — LOCATION (City, town, or county) (State): Annapolis, Md.

DATE REC'D BY LOCAL REGISTRAR: 10/19/54 — REGISTRAR'S SIGNATURE: [signature]

24. FUNERAL DIRECTOR: Annie A. Johnson — ADDRESS: Annapolis, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09042

CERTIFICATE OF DEATH

09029B

Reg. Dist. No.

Item 11 FilmG171 10-15-54 et

1. PLACE OF DEATH:
COUNTY A A Co. MARYLAND
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN Glenburnie P.O.
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Glenburnie P.O. Md
STREET ADDRESS (If rural give location)

3. NAME OF DECEASED: (Type or Print) (First) Bertie (Middle) (Last) Jackson

4. DATE OF DEATH: (Month) 10 (Day) 5 (Year) 1954

5. SEX: F | 6. COLOR OR RACE: C | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): M | 8. DATE OF BIRTH: 12/3/1892 | 9. AGE last birthday: 61 yrs. | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired):

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Glen Burnie, Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Charles Howard

14. MOTHER'S MAIDEN NAME: Eliza Brown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)

(If Yes, give war or dates of service)

16. SOCIAL SECURITY No.:

17. INFORMANT & ADDRESS: Elsie Hutton (Pasadena)

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) DUE TO: Congestive Heart Failure — Interval Between Onset And Death: 5 years

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.

(b) DUE TO: Hypertension — 5 years

(c)

II OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Herpes Zoster — 1 month

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Aug. 10, 1954, to Oct. 5, 1954, that I last saw the deceased alive on Oct. 4, 1954, and that death occurred at 6:12 A.M., from the causes and on the date stated above.

SIGNATURE R. M. McLaughlin (Degree or title) M.D. ADDRESS Pasadena, Md. DATE SIGNED October 5, 1954

23. BURIAL, CREMATION, REMOVAL (Specify) Burial | DATE THEREOF 10/10/54 | NAME OF CEMETERY OR CREMATORY Halls Cem | LOCATION (City, town, or county) (State) A A Co. Md

DATE REC'D BY LOCAL REGISTRAR 10-7-54 | REGISTRAR'S SIGNATURE A. W. Hudson

24. FUNERAL DIRECTOR Isaac L. Brown & Son ADDRESS 108 W Montgomery St

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

09043 C.9030

MARYLAND

STATE DEPARTMETT OF HEALTH

CERTIFICATE OF DEATH

Reg. Dist. No. 21

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH
COUNTY Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
LENGTH OF STAY (in this place) MARYLAND
HOSPITAL OR INSTITUTION OR STREET ADDRESS Rt. 2 Box 353

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE Maryland COUNTY A. A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
STREET ADDRESS (If rural, give location) Rt. 2 Box 353

3. NAME OF DECEASED (Type or Print) (First) Andrew (Middle) — (Last) Johnson

4. DATE OF DEATH (Month) 10 (Day) 31 (Year) 1954

5. SEX Male

6. COLOR OR RACE Colored

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) M

8. DATE OF BIRTH 7-22-1877

9. AGE Last birthday 82 yrs. If under 1 year: Months | Days | If under 24 hrs.: Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired

10b. KIND OF BUSINESS OR INDUSTRY Domestic

11. BIRTHPLACE (State or foreign country) Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Carroll Johnson

14. MOTHER'S MAIDEN NAME Lizzie Nicholas

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 214-14-3829

17. INFORMANT AND ADDRESS Rachel Johnson - Annapolis, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Cerebral Hemorrhage — Interval Between Onset and Death: 1 day

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) due to arteriosclerotic Hypertension — 2 yrs.

(c) Cardiorenal Disease

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from May 7, 1953, to Oct 31, 1954, that I last saw the deceased alive on Oct 31, 1954, and that death occurred at 8:30 p.m., from the causes and on the date stated above.

SIGNATURE R. F. Weber and Assoc. (Degree or title) M.D. ADDRESS 110 Clay Street Annapolis, Md. DATE SIGNED 11/3/54

23. BURIAL, CREMATION / REMOVAL (Specify) DATE Nov 5-54 NAME OF CEMETERY OR CREMATORY Parole Cemetery LOCATION (City, town, or county) Annapolis (State) Md.

DATE REC'D BY LOCAL REG. Nov. 3, 1954

REGISTRAR'S SIGNATURE W. D. Council

24. FUNERAL DIRECTOR Thomas F. Green ADDRESS 128 Northwest St. Annapolis, Md.

09031

MARYLAND 09003

STATE DEPARTMETT OF HEALTH

CERTIFICATE OF DEATH

Reg. Dist. No. 21

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH
COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS 32 Calvert St.

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE Maryland COUNTY A. A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
STREET ADDRESS (If rural, give location) 32 Calvert St.

3. NAME OF DECEASED (Type or Print) (First) Louise (Middle) Brown (Last) Johnson

4. DATE OF DEATH (Month) (Day) (Year) 10 10 1954

5. SEX Female

6. COLOR OR RACE Colored

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) M.

8. DATE OF BIRTH 8-13-1912

9. AGE last birthday 42 yrs. If under 1 year: Months, Days. If under 24 hrs.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic

10b. KIND OF BUSINESS OR INDUSTRY Home

11. BIRTHPLACE (State or foreign country) Annapolis, Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME William Brown Sr.

14. MOTHER'S MAIDEN NAME Agnes Brooks

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT AND ADDRESS Agnes B. Brown - Annapolis, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Bronchopneumonia (Acute) — Interval Between Onset and Death: Oct 4, 1954

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Acute (c) Acute Influenza

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT (Specify) SUICIDE HOMICIDE

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Oct 4, 1954, to Oct 10, 1954, that I last saw the deceased alive on Oct 10, 1954, and that death occurred at 10:50 a.m., from the causes and on the date stated above.

SIGNATURE Dr. Richard Orr (Degree or title) MD ADDRESS 110 Clay Street Annapolis DATE SIGNED 10/11/54

23. BURIAL, CREMATION, REMOVAL (Specify) Burial DATE 10-13-54 NAME OF CEMETERY OR CREMATORY Green Hill LOCATION (City, town, or county) Annapolis, Md. (State)

DATE REC'D BY LOCAL REG. 10-11-54 REGISTRAR'S SIGNATURE Edw. Hedrick

24. FUNERAL DIRECTOR Dibiasi Bros. ADDRESS 1-10 Washington St. Annapolis, Md.

09044

09032

MARYLAND

STATE DEPARTMETT OF HEALTH

CERTIFICATE OF DEATH

Reg. Dist. No. 28

1. PLACE OF DEATH
COUNTY: Anne Arundel — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Crownsville
LENGTH OF STAY (In this place): 2yrs. 10mos.
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Crownsville State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland — COUNTY: Prince George's
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Fairmount Heights
STREET ADDRESS (If rural, give location): 1116 64th Street ✓

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Mary	Ford	Johnson	10	10	1954

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
Female	Negro	Widow	5/5/67	87 yrs.	—	—	—	—

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Domestic
10b. KIND OF BUSINESS OR INDUSTRY: Housework
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME: Harry Courts
14. MOTHER'S MAIDEN NAME: Lucy Ford
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Unk.
(If yes, give war or dates of service): Unk.
16. SOCIAL SECURITY NO.: Unk.
17. INFORMANT AND ADDRESS: Hospital Records

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a): Cardiac Failure
Antecedent cause(s) — Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b): Arteriosclerotic Hypertension
(c):

INTERVAL BETWEEN ONSET AND DEATH: 9 months

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: — — — — —
19b. MAJOR FINDINGS OF OPERATION: — — — — — — — — — — — — — — — — — —
20. AUTOPSY? Yes ☑ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify): — — —
PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY: — — —
(CITY OR TOWN) (COUNTY) (STATE): — — — — — — — — — — — — — — — — — —
TIME OF INJURY (Month) (Day) (Year) (Hour): — — — — m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR? — — — — — — — — — — — — — — — — — —

22. I hereby certify that I attended the deceased from 11/28, 19 51, to 10/10, 19 54, that I last saw the deceased alive on 10/10, 19 54, and that death occurred at 10:45 p. m., from the causes and on the date stated above.
SIGNATURE: [signature] (Degree or title)
ADDRESS: Crownsville, Md.
DATE SIGNED: 10/11/54

23. BURIAL, CREMATION, REMOVAL (Specify)
DATE: 10/14/54
NAME OF CEMETERY OR CREMATORY: Crownsville State Hospital
LOCATION (City, town, or county) (State): Crownsville, Maryland

DATE REC'D BY LOCAL REG.: 10-14-54
REGISTRAR'S SIGNATURE: [signature]
24. FUNERAL DIRECTOR: Arnold H. Eckert M.D.
ADDRESS: Crownsville, Md.

MARGIN RESERVED FOR BINDING

09045 09033

MARYLAND STATE DEPARTMETT OF HEALTH

CERTIFICATE OF DEATH

Reg. Dist. No. 28

1. PLACE OF DEATH: COUNTY Anne Arundel; MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Crownsville; LENGTH OF STAY (In this place) 1 mo.; HOSPITAL OR INSTITUTION OR STREET ADDRESS Crownsville State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Frederick; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Ironville; STREET ADDRESS (If rural, give location) Route #1

3. NAME OF DECEASED (Type or Print): (First) Minerva (Middle) Lavina (Last) Johnson

4. DATE OF DEATH: (Month) 10 (Day) 8 (Year) 19 54

5. SEX: Female

6. COLOR OR RACE: Negro

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed

8. DATE OF BIRTH: 1864?

9. AGE last birthday: 80? yrs. If under 1 year: Months —; Days —; If under 24 hrs.: Hours —; Min. —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Unknown

10b. KIND OF BUSINESS OR INDUSTRY: Unknown

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Unk. (If year, give war or dates of service) Unk.

16. SOCIAL SECURITY NO.: Unk.

17. INFORMANT AND ADDRESS: Hospital Records

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Chronic Myocarditis — Interval Between Onset and Death: Known to us since 9/8/54

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Generalized Arteriosclerosis

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: — — —

19b. MAJOR FINDINGS OF OPERATION: — — — — — — — — — — — — — — — — — —

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) —

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY — —

(CITY OR TOWN) — — — — — — — (COUNTY) (STATE)

TIME OF INJURY (Month) — (Day) — (Year) — (Hour) — m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR? — — — — — — —

22. I hereby certify that I attended the deceased from 9/8, 19 54, to 10/8, 19 54, that I last saw the deceased alive on 10/8, 19 54, and that death occurred at 3:30 p. m., from the causes and on the date stated above.

SIGNATURE [signature] (Degree or title) ADDRESS Crownsville, Md. DATE SIGNED 10/8/54

23. BURIAL, CREMATION, REMOVAL (Specify) Burial | DATE Oct 11 1954 | NAME OF CEMETERY OR CREMATORY Fountain Hill | LOCATION (City, town, or county) Frederick Co (State) Md

DATE REC'D BY LOCAL REG. 10-14-54 | REGISTRAR'S SIGNATURE [signature]

24. FUNERAL DIRECTOR Roy L. Babylonville ADDRESS

MARGIN RESERVED FOR BINDING

09046

09034

MARYLAND

STATE DEPARTMETT OF HEALTH

CERTIFICATE OF DEATH

Reg. Dist. No. 28

1. PLACE OF DEATH
COUNTY: Anne Arundel — STATE: MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Crownsville
LENGTH OF STAY (In this place): 11 mos. 4days
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Crownsville State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland — COUNTY: Baltimore City
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Baltimore City
STREET ADDRESS (If rural, give location): 507 W. Lee Street

3. NAME OF DECEASED (Type or Print): (First) Rosa (Middle) (Last) Johnson

4. DATE OF DEATH: (Month) 10 (Day) 9 (Year) 19 54

5. SEX: Female

6. COLOR OR RACE: Negro

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): Widow

8. DATE OF BIRTH: 1901?

9. AGE last birthday: 53? yrs. If under 1 year: Months. — Days — If under 24 hrs.: Hours — Min. —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Unknown

10b. KIND OF BUSINESS OR INDUSTRY: Unknown

11. BIRTHPLACE (State or foreign country): North Carolina

12. CITIZEN OF WHAT COUNTRY? Unk.

13. FATHER'S NAME: Millard Edison

14. MOTHER'S MAIDEN NAME: Palmore

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Unk. (If yes, give war or dates of service): Unk.

16. SOCIAL SECURITY NO.: Unk.

17. INFORMANT AND ADDRESS: Hospital Records

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Chronic Myocarditis — Interval between onset and death: Known to us since 11/5/53

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Generalized Arteriosclerosis

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: - - - - - -

19b. MAJOR FINDINGS OF OPERATION: -

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify): - - - - - -

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY: - - -

(CITY OR TOWN) - - - - - - - - - - - - (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) - - - - - - - m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR? - - - - - - - - - - - - - -

22. I hereby certify that I attended the deceased from 11/5, 19 53, to 10/9, 19 54, that I last saw the deceased alive on 10/9, 19 54, and that death occurred at 9:45 a. m., from the causes and on the date stated above.

SIGNATURE: L Jewell Mc (Degree or title) ADDRESS: Crownsville, Md. DATE SIGNED: 10/9/54

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE: Oct 14.54 — NAME OF CEMETERY OR CREMATORY: Mt Auburn — LOCATION (City, town, or county) (State): Catts Mad

DATE REC'D BY LOCAL REG.: 10/12/54 — REGISTRAR'S SIGNATURE: A. W. Hedrick

24. FUNERAL DIRECTOR: Isaac L Brown Son — ADDRESS: 1084 W Mulberry Street

98.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 09035

09047 **CERTIFICATE OF DEATH** Reg. Dist. No. 28

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15—10-52

1. PLACE OF DEATH:
COUNTY Anne Arundel MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville
LENGTH OF STAY (in this place) 4 yrs. 7 mos
HOSPITAL OR INSTITUTION OR STREET ADDRESS Crownsville State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Dorchester
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge
STREET ADDRESS (If rural give location) Unknown

3. NAME OF DECEASED: (Type or Print) (First) Lillie (Middle) (Last) Jones

4. DATE OF DEATH: (Month) 10 (Day) 1 (Year) 19 54

5. SEX: Female

6. COLOR OR RACE: Negro

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widow

8. DATE OF BIRTH: 1880?

9. AGE last birthday 74? yrs. IF UNDER 1 YEAR Months — Days — IF UNDER 24 HRS. Hours — Min. —

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Unemployed

10B. KIND OF BUSINESS OR INDUSTRY: Unk.

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME: James Sampson

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) Unk. (If Yes, give war or dates of service) Unk.

16. SOCIAL SECURITY NO. Unk.

17. INFORMANT & ADDRESS: Hospital Records

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

IMMEDIATE CAUSE (A) Chronic Myocarditis — INTERVAL BETWEEN ONSET AND DEATH: Known to us since 2/24/50

ANTECEDENT CAUSE (S) DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) Hypertensive Heart Disease DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Generalized Arteriosclerosis - Senility

19A. DATE OF OPERATION: — — — —

19B. MAJOR FINDINGS OF OPERATION — — — — — — — — — — — — — — — — — —

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.

21C. WHERE DID (City or town) (County) (State) INJURY OCCUR? — — — — — — —

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY — — — — M.

21E. INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR? — — — — — — — — —

22. I hereby certify that I attended the deceased from 10/6, 1952, to 10/1, 19 54 that I last saw the deceased alive on 10/1 54, and that death occurred at 9:20 P.M., from the causes and on the date stated above.

SIGNATURE S. Tolson E. Kramer M.D. ADDRESS Crownsville, Md. DATE SIGNED 10/4/54

23. BURIAL, CREMATION, REMOVAL (SPECIFY) — DATE THEREOF 10/7/54 — NAME OF CEMETERY OR CREMATORY — LOCATION (City, town, or county) (State)

DATE REC'D BY LOCAL REGISTRAR Oct 19 1954 — REGISTRAR'S SIGNATURE Katherine M. Joyce Deputy Registrar

24. FUNERAL DIRECTOR — ADDRESS

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 09036

09043 CERTIFICATE OF DEATH Reg. Dist. No. .....

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15—10-52

1. PLACE OF DEATH:
COUNTY Anne Arundel MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) West River
LENGTH OF STAY (in this place) 7 years
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md COUNTY Anne Arundel
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) West River
STREET ADDRESS (If rural give location)

3. NAME OF DECEASED: (Type or Print) (First) Martha (Middle) (Last) Jones

4. DATE OF DEATH: (Month) Oct (Day) 7 (Year) 1954

5. SEX: Female

6. COLOR OR RACE: Colored

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): Widowed

8. DATE OF BIRTH: 1875

9. AGE last birthday: 79 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Domestic

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Huntingtown Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Major Johnson

14. MOTHER'S MAIDEN NAME: Frances Johnson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) no (If Yes, give war or dates of service) no

16. SOCIAL SECURITY NO. no

17. INFORMANT & ADDRESS: Matilda Dorsey, West River, Md.

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

IMMEDIATE CAUSE (A) Coronary occlusion

ANTECEDENT CAUSE (B) DUE TO Generalized arteriosclerosis

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) DUE TO hypertension

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION: 19B. MAJOR FINDINGS OF OPERATION 20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M. 21E. INJURY OCCURRED While at work ☐ Not while at work ☐ 21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July 1, 1952 to Oct 7, 1954, that I last saw the deceased alive on Sept 20, 1954, and that death occurred at 8:30 PM, from the causes and on the date stated above.

SIGNATURE Emily H. Wilson, M.D. ADDRESS Lothian, Md. DATE SIGNED Oct 8, 1954

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | DATE THEREOF Oct 10 1954 | NAME OF CEMETERY OR CREMATORY Union Chapel | LOCATION (City, town, or county) (State) McKendree Md

DATE REC'D BY LOCAL REGISTRAR 10-9-54 | REGISTRAR'S SIGNATURE Elsie Mae Williams | 24. FUNERAL DIRECTOR T A Hardesty & Son | ADDRESS Lothian Md

RECEIVED
OCT 13 1954
U. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 09049 09037

CERTIFICATE OF DEATH

Reg. Dist. No. .. ..

1. PLACE OF DEATH: CROWNSVILLE
COUNTY AA MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CROWNSVILLE
LENGTH OF STAY (in this place) 5y 8 mos
HOSPITAL OR INSTITUTION OR STREET ADDRESS CROWNSVILLE STATE HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE MD COUNTY BALTO., CITY
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE
STREET ADDRESS (If rural give location) 2295 N. FULTON Ave.

3. NAME OF DECEASED: (Type or Print) (First) FRANKLIN (Middle) V. (Last) KERR

4. DATE OF DEATH: (Month) 10 (Day) 23 (Year) 1954

5. SEX: M

6. COLOR OR RACE: NEGRO

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): M

8. DATE OF BIRTH: May 28, 1898

9. AGE last birthday 56(?) yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Musician

10B. KIND OF BUSINESS OR INDUSTRY: Orchestra

11. BIRTHPLACE (State or foreign country): Cambridge, Md

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Charles Kerr

14. MOTHER'S MAIDEN NAME: Mamie Floyd

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) NO (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO. 215-14-0005

17. INFORMANT & ADDRESS: Mrs OPHELIA KERR 2259 N. FULTON Ave., BALTO.

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

IMMEDIATE CAUSE (A) MYOCARDITIS

ANTECEDENT CAUSE (S) DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO GENERAL PARESIS

(C)

INTERVAL BETWEEN ONSET AND DEATH

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.

21E. INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 2-9, 19.49 to 10/23, 1954, that I last saw the deceased alive on 10/23, 1954, and that death occurred at 3:45 A M, from the causes and on the date stated above.

SIGNATURE [signature] M. D. ADDRESS CROWNSVILLE STATE HOSP. DATE SIGNED 10/23/54

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial

DATE THEREOF Oct. 28, 1954

NAME OF CEMETERY OR CREMATORY Mt. Auburn

LOCATION (City, town, or county) (State) Baltimore, Md.

DATE REC'D BY LOCAL REGISTRAR 10-27-54

REGISTRAR'S SIGNATURE [signature]

24. FUNERAL DIRECTOR Funeral ADDRESS Home 1631 Druid Hill Ave.

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15—10-53

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09050

CERTIFICATE OF DEATH

Reg. Dist. No. 09038

1. PLACE OF DEATH:
COUNTY Anne Arundel MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville
LENGTH OF STAY (in this place) 1 yr. 15 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS Crownsville State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Baltimore City
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore City
STREET ADDRESS (If rural give location) 744 W. Mulberry Street

3. NAME OF DECEASED: (First) CHARLOTTE (Middle) (Last) LEWIS

4. DATE OF DEATH: (Month) 10 (Day) 31 (Year) 1954

5. SEX: Female

6. COLOR OR RACE: Negro

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widow

8. DATE OF BIRTH: 1885

9. AGE last birthday: 69 yrs. IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS.: Hours — Min. —

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Unemployed

10B. KIND OF BUSINESS OR INDUSTRY: — — —

11. BIRTHPLACE (State or foreign country): Undetermined

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) Unk. (If Yes, give war or dates of service) Unk.

16. SOCIAL SECURITY NO. Unk;

17. INFORMANT & ADDRESS: Hospital Records

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

IMMEDIATE CAUSE (A) Congestive Heart Failure

ANTECEDENT CAUSE (B) DUE TO Chronic Myocardial Disease

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST (C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Generalized Arteriosclerosis

19A. DATE OF OPERATION: — — — — —

19B. MAJOR FINDINGS OF OPERATION — — — — — — — — — — — — — — —

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) — — — — —

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State) — — — — — — — — — —

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) — — — — — — M.

21E. INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR? — — — — — — — — — — — —

22. I hereby certify that I attended the deceased from 10/16, 19 53 to 10/31, 19 54, that I last saw the deceased alive on 10/31, 1954, and that death occurred at 9.15 P. M, from the causes and on the date stated above.

SIGNATURE Guilford E. Naranjit M. D. ADDRESS DATE SIGNED 10-31-54

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial

DATE THEREOF Nov 4

NAME OF CEMETERY OR CREMATORY Mt Auburn

LOCATION (City, town, or county) (State)

DATE REC'D BY LOCAL REGISTRAR 11-4-54

REGISTRAR'S SIGNATURE G. M. Hedrick

24. FUNERAL DIRECTOR C. A. Halsted

ADDRESS 915 Dtyk Ave

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15 — 10 - 53

09051

09039

MARYLAND

STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

Reg. Dist. No. 28

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH- COUNTY: Anne Arundel — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Crownsville
LENGTH OF STAY (In this place): 4mos, 23 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Crownsville State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED- STATE: Maryland — COUNTY: Baltimore City
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Baltimore City
STREET ADDRESS (If rural, give location): 1350 Stockton Street

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Vernell	James	Mason	10	14	1954

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
Female	Negro	Married	1916	38 yrs.	—	—	—	—

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Unemployed
10b. KIND OF BUSINESS OR INDUSTRY: - - - -
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY: U. S.
13. FATHER'S NAME: John James
14. MOTHER'S MAIDEN NAME: Minnie James
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If year, give war or dates of service): No
16. SOCIAL SECURITY NO.: Unknown
17. INFORMANT AND ADDRESS: Hospital Records

MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

			INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a)	Uremia	48 hours
Antecedent cause(s) Disease or conditions, if any, giving rise to the above cause stating the underlying cause last	(b)	Bilateral Hydronephrosis	Known to us since 5/21/54
	(c)		

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death: Diabetes Mellitus, Chronic Myocarditis — Known to us since 5/21/54

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
- - - -	- - - - - - - - - - - - - - - - - - - -	Yes ☐ No ☑

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
- - - -	- - - -	- - - -		

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
- - - - - m.		- - - - -

22. I hereby certify that I attended the deceased from 5/21/, 1954, to 10/14, 1954, that I last saw the deceased alive on 10/14/, 1954, and that death occurred at 1:15 a. m., from the causes and on the date stated above.

SIGNATURE (Degree or Title): [signature] — ADDRESS: Crownsville, Md. — DATE SIGNED: 10/14/54

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	10-19-54	Arbutus	md

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
10-15-54	[signature]	Jorge S. Nelson	1203 Eastman st

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09004 **CERTIFICATE OF DEATH** 09040

Reg. Dist. No. 2

M

1

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH:
COUNTY Anne Arundel — MARYLAND
CITY (If outside corporate limits, write RURAL) OR TOWN (and give nearest town) Annapolis
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS 32 Calvert St.

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland — COUNTY A. A.
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis
STREET ADDRESS (If rural give location) 32 Calvert St.

3. NAME OF DECEASED: (Type or Print) (First) James (Middle) L. (Last) Matthews

4. DATE OF DEATH: (Month) 10 (Day) 9 (Year) 1954

5. SEX: Male

6. COLOR OR RACE: Wh.

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): S.

8. DATE OF BIRTH: 11-6-1908

9. AGE Last birthday: 45 yrs. — IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired: Painter

10b. KIND OF BUSINESS OR INDUSTRY: Annapolis City

11. BIRTHPLACE (State or foreign country): Shadyside, Md

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Joseph Matthews

14. MOTHER'S MAIDEN NAME: Mary E. Crowner

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or Unk.) No

16. SOCIAL SECURITY No.: 218-16-3356

17. INFORMANT & ADDRESS: Dorthy Green - Annapolis, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Cardiac Failure

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. DUE TO (b) Metal Insufficiency

DUE TO (c)

Interval Between Onset And Death: 3 days

II OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT (Specify) / SUICIDE / HOMICIDE — PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — (CITY OR TOWN) — (COUNTY) — (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURED While at Work ☐ Not While At Work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 10/8, 1954 to 10/9, 1954, that I last saw the deceased alive on 10/8, 1954, and that death occurred at 2.30 AM, from the causes and on the date stated above.

SIGNATURE Theodore A. Johnson (Degree or title) M.D. ADDRESS 37 Calvert Street DATE SIGNED Annapolis 10/9/54

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE THEREOF Oct. 12 54 — NAME OF CEMETERY OR CREMATORY Brewer Hill — LOCATION (City, town, or county) Annapolis (State)

DATE REC'D BY LOCAL REGISTRAR Oct. 12, 1954 — REGISTRAR'S SIGNATURE J. O. Council

24. FUNERAL DIRECTOR William Rea II — ADDRESS 108 Northumberland Annapolis Md

OCT 14 1954

BUREAU V. S.

09052 09041

MARYLAND

STATE DEPARTMETT OF HEALTH

CERTIFICATE OF DEATH

Reg. Dist. No. 28

1. PLACE OF DEATH: COUNTY Anne Arundel; MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Crownsville; LENGTH OF STAY (In this place) 9yrs. 8mos.; HOSPITAL OR INSTITUTION OR STREET ADDRESS Crownsville State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Baltimore City; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore City 3Vc 1. 4.; STREET ADDRESS (If rural, give location) 412 Eisler Street

3. NAME OF DECEASED (Type or Print)	(First)	(Middle)	(Last)	4. DATE OF DEATH	(Month)	(Day)	(Year)
	John	E.	McClellan		10	17	19 54

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
Male	Negro	Widowed	Sept-19-1875	79 yrs.	—	—	—	—

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10b. KIND OF BUSINESS OR INDUSTRY: Unknown

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME: Mike McClellan

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No

(If year, give war or dates of service): None

16. SOCIAL SECURITY NO.: Unk.

17. INFORMANT AND ADDRESS: Hospital Records

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Cardio-vascular disease — Interval between onset and death: 6 days

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Generalized Arteriosclerosis — Known to us since admission 2/2/45

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
— — — — —	— — — — — — — — — — — —	Yes ☐ No ☑

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
— — — — —	— — — — —	— — — — —	— — — — —	— — — — —

TIME OF INJURY (Month)	(Day)	(Year)	(Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
— — — — —			m.		— — — — — — — — — — — —

22. I hereby certify that I attended the deceased from 1/21/48, 19..., to 10/17, 19 54, that I last saw the deceased alive on 10/17, 19 54, and that death occurred at 7:25 a.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) [signature] ADDRESS Crownsville, Md. DATE SIGNED 10/17/54

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	10-21-54	Mt. Olivet Cem.	Baltimore Md

DATE REC'D BY LOCAL REG. 10-18-54 | REGISTRAR'S SIGNATURE A.W. Hedrick | 24. FUNERAL DIRECTOR Edward O. Wilson | ADDRESS 1000 Bentley Rd

MARGIN RESERVED FOR BINDING

NT

MARYLAND 09053

09042

STATE DEPARTMETT OF HEALTH

CERTIFICATE OF DEATH

Reg. Dist. No. 23

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH
COUNTY Balto Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Harley Mem
LENGTH OF STAY (in this place) 2 months
HOSPITAL OR INSTITUTION OR STREET ADDRESS 101. Frist Ave Glenburnie

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE md COUNTY Balto
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Fullerton.
STREET ADDRESS (If rural, give location) 7830 Belair Rd

3. NAME OF DECEASED (Type or Print) (First) Catherine (Middle) Lydia (Last) Mitchell

4. DATE OF DEATH (Month) 10 (Day) 18 (Year) 1954

5. SEX Female

6. COLOR OR RACE White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widow

8. DATE OF BIRTH Jan 1-1880

9. AGE last birthday 74 yrs. If under 1 year Months. Days. If under 24 hrs Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tailor

10b. KIND OF BUSINESS OR INDUSTRY Adelaman

11. BIRTHPLACE (State or foreign country) Balto Co md

12. CITIZEN OF WHAT COUNTRY? U S a

13. FATHER'S NAME Henry Wildberger

14. MOTHER'S MAIDEN NAME Louise Glatzel

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service) No

16. SOCIAL SECURITY NO. 217-16-35-93 A

17. INFORMANT AND ADDRESS Glenburnie Mrs Mollie Baxter R.R.#1. 101. Frist Ave

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Diabetes Mellitus — Interval Between Onset and Death 15 yrs.

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Sept -, 1952, to Sept -, 1954, that I last saw the deceased alive on Sept 15, 1954, and that death occurred at 7:10 P. m., from the causes and on the date stated above.

SIGNATURE C. H. MacKenzie M.D. (Degree or title) Salem & Wilson, Balto (ADDRESS) DATE SIGNED 10-18-54.

23. BURIAL, CREMATION, REMOVAL (Specify) Burial | DATE 10/21/54 | NAME OF CEMETERY OR CREMATORY Parkwood Cem | LOCATION (City, town, or county) (State) Balto Md

DATE REC'D BY LOCAL REG. 10-20-54 | REGISTRAR'S SIGNATURE O. N. Hebrid | 24. FUNERAL DIRECTOR Loveless Funeral Home 7401. Belair Rd (ADDRESS)

J. K

09643

MARYLAND 09005

STATE DEPARTMETT OF HEALTH

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH
COUNTY: Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Annapolis
LENGTH OF STAY (in this place): MARYLAND 10
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 13 N. Woodlawn Ave.

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland COUNTY: Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Annapolis
STREET ADDRESS (If rural, give location): 13 N. Woodlawn Ave.

3. NAME OF DECEASED (Type or Print): (First) AGNES (Middle) A (Last) MYERS

4. DATE OF DEATH: (Month) OCTOBER (Day) 13, (Year) 1954

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: May 2, 1882

9. AGE last birthday: 72 yrs. If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House wife

10b. KIND OF BUSINESS OR INDUSTRY: own home

11. BIRTHPLACE (State or foreign country): Anne Arundel County, Maryland

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: James W. KERR

14. MOTHER'S MAIDEN NAME: Elizabeth Cranford

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) ---- (If year, give war or dates of service) ---

16. SOCIAL SECURITY NO.: none

17. INFORMANT AND ADDRESS: Mr. Edwin D. Myers; Husband; same as # 2

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Carcinomatosis — Interval between onset and death: 6 mon

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Melanotic Sarcoma — 1 yr.

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: —

19b. MAJOR FINDINGS OF OPERATION: —

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify): —

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY: — (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour): — m.

INJURY OCCURRED While at Work ☐ —Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from any, 195-1, to 10/12/, 1954, that I last saw the deceased alive on 10/10/ 1954, and that death occurred at 12 45 A m., from the causes and on the date stated above.

SIGNATURE: Frank M Shipley (Degree or title) MD ADDRESS: Annapolis, Md DATE SIGNED: 10/14/54

23. BURIAL, CREMATION, REMOVAL (Specify): Burial
DATE: Oct. 16, 54
NAME OF CEMETERY OR CREMATORY: St. Mary's Cemetery
LOCATION (City, town, or county) (State): Annapolis, Maryland

DATE REC'D BY LOCAL REG.: Oct. 15, 1954
REGISTRAR'S SIGNATURE: [signature]

24. FUNERAL DIRECTOR: B. n L. Hopping and Son ADDRESS: Annapolis, Md.

MARGIN RESERVED FOR BINDING

MARYLAND 09054 69044

STATE DEPARTMETT OF HEALTH

CERTIFICATE OF DEATH

Reg. Dist. No. .....

1. PLACE OF DEATH
COUNTY Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Harwood
MARYLAND
LENGTH OF STAY (In this place) all life
HOSPITAL OR INSTITUTION OR STREET ADDRESS Home

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE Maryland COUNTY A. A. Co.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Harwood.
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) (First) COMPton (Middle) RoBERT (Last) PADDY

4. DATE OF DEATH (Month) Oct. (Day) 5 (Year) 1954

5. SEX male

6. COLOR OR RACE white

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)

8. DATE OF BIRTH September 17 1879

9. AGE last birthday 75 yrs. If under 1 year: Months. Days 19 d. If under 24 hrs.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer

10b. KIND OF BUSINESS OR INDUSTRY tobacco

11. BIRTHPLACE (State or foreign country) a. a. County, Md yes d

12. CITIZEN OF WHAT COUNTRY? U.S.a.

13. FATHER'S NAME Robert Paddy

14. MOTHER'S MAIDEN NAME maggie Mock.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT (NAME AND ADDRESS) [illegible]

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) ..... Coronary occlusion

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) .... generalized arteriosclerosis

(c) .....

INTERVAL BETWEEN ONSET AND DEATH

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION none

19b. MAJOR FINDINGS OF OPERATION none

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) no

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Sept 6, 1954, to Oct 6, 1954, that I last saw the deceased alive on Oct 5, 1954, and that death occurred at 5:30 p.m., from the causes and on the date stated above.

SIGNATURE Emily H. Wilson, M.D. (Degree or title) ADDRESS Catterin, Md. DATE SIGNED 10-6-54.

23. BURIAL, ~~CREMATION~~ REMOVAL (Specify) DATE 10-9-54 NAME OF CEMETERY OR CREMATORY Mt Zion Cem LOCATION (City, town, or county) (State) Mt Zion A A Co Md.

DATE REC'D BY LOCAL REG. Oct. 6, 1954 REGISTRAR'S SIGNATURE [illegible]

24. FUNERAL DIRECTOR John M. Taylor Sons ADDRESS Annapolis Md.

MARGIN RESERVED FOR BINDING

MARYLAND 09006

19045

STATE DEPARTMETT OF HEALTH

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH
COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS 122 South St.

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE Maryland COUNTY A. A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
STREET ADDRESS (If rural, give location) 122 South St.

3. NAME OF DECEASED (Type or Print) (First) George (Middle) H (Last) Parker

4. DATE OF DEATH (Month) 10 (Day) 19 (Year) 1954

5. SEX Male

6. COLOR OR RACE Colored

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) M.

8. DATE OF BIRTH 11-17-1873

9. AGE Last birthday 80 yrs. | If under 1 year Months | Days | If under 24 hrs. Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Janitor

10b. KIND OF BUSINESS OR INDUSTRY Stores

11. BIRTHPLACE (State or foreign country) Maryland

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME William Parker

14. MOTHER'S MAIDEN NAME Aleatha Parker

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No

16. SOCIAL SECURITY NO. (If year, give war or dates of service) 21-05-4253

17. INFORMANT AND ADDRESS Lillie A. Parker - Annapolis, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Acute Coronary Thrombosis — Interval Between Onset and Death: 12 hrs

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) General Arterio Sclerosis + Hypertension — Interval Between Onset and Death: Several yrs

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Oct 3 ..., 1954, to Oct 19 ..., 1954, that I last saw the deceased alive on Oct 19 ..., 1954, and that death occurred at 4.55 P m., from the causes and on the date stated above.

SIGNATURE (Degree or title) J. Lewis Purvis M.D. ADDRESS Annapolis Md DATE SIGNED 10/21/54

23. BURIAL, CREMATION, REMOVAL (Specify) Buried DATE 10-22-54 NAME OF CEMETERY OR CREMATORY Brewer's LOCATION (City, town, or county) Annapolis (State) Md.

DATE REC'D BY LOCAL REG. 10/21/54

REGISTRAR'S SIGNATURE H. O. Brown

24. FUNERAL DIRECTOR ADDRESS Thompkins-109 E. Washington St. Annapolis, Md.

M

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MARGIN RESERVED FOR BINDING

09055

09046

MARYLAND

STATE DEPARTMETT OF HEALTH

CERTIFICATE OF DEATH

Reg. Dist. No. 28

1. PLACE OF DEATH
COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Crownsville
LENGTH OF STAY (in this place) 1 yr. 9 mos.
HOSPITAL OR INSTITUTION OR STREET ADDRESS Crownsville State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE Maryland COUNTY St. Mary's
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Charlotte Hall
STREET ADDRESS (If rural, give location) None listed

3. NAME OF DECEASED (Type or Print) (First) Hanson (Middle) (Last) Plater

4. DATE OF DEATH (Month) 10 (Day) 7 (Year) 1954

5. SEX Male

6. COLOR OR RACE Negro

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Separated

8. DATE OF BIRTH 7/7/66

9. AGE Last birthday 88 yrs. If under 1 year: Months — Days — If under 24 hrs.: Hours — Min. —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unemployed

10b. KIND OF BUSINESS OR INDUSTRY — — —

11. BIRTHPLACE (State or foreign country) Maryland

12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME Unknown

14. MOTHER'S MAIDEN NAME Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Unk. (If year, give war or dates of service) Unk.

16. SOCIAL SECURITY NO. Unk.

17. INFORMANT AND ADDRESS Hospital Records

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

422.1

Immediate cause (a) Chronic Myocarditis — Known to us since 1/7/53

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Generalized Arteriosclerosis

(c)

INTERVAL BETWEEN ONSET AND DEATH

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION — 19b. MAJOR FINDINGS OF OPERATION —

20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) — PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY — (CITY OR TOWN) — (COUNTY) — (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) — m. — INJURY OCCURRED While at Work ☐ Not While At work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1/7 ..., 1953, to 10/7 ..., 1954, that I last saw the deceased alive on 10/7 1954, and that death occurred at 9:40p. m., from the causes and on the date stated above.

SIGNATURE [signature] (Degree or title) ADDRESS Crownsville, Md. DATE SIGNED 10/8/54

23. BURIAL, CREMATION, REMOVAL (Specify) Burial — DATE Oct. 10, 1954 — NAME OF CEMETERY OR CREMATORY Mt. Calvary M.E. — LOCATION (City, town, or county) (State) New Market, Md.

DATE RECD BY LOCAL REG. 11/10/54 — REGISTRAR'S SIGNATURE Katherine M. Joyce — 24. FUNERAL DIRECTOR Abbott & Ryon — ADDRESS Waldorf, Md.

MARGIN RESERVED FOR BINDING

RECEIVED
OCT 14 1954
BUREAU U. S.

MARYLAND 09007

09947
STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH
COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis | LENGTH OF STAY (In this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Anne Arundel General

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE Maryland COUNTY Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Severn
STREET ADDRESS (If rural, give location) Delmont Sta

3. NAME OF DECEASED (Type or Print): (First) Amelia (Middle) (Last) Polacek
4. DATE OF DEATH: (Month) 10 (Day) 22 (Year) 1954
5. SEX: F
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): married
8. DATE OF BIRTH: Sept. 21, 1895
9. AGE last birthday: 59 yrs. | If under 1 year: Months, Days | If under 24 hrs.: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): Germany
12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME: Antonne Kovla
14. MOTHER'S MAIDEN NAME: ?
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No | (If year, give war or dates of service):
16. SOCIAL SECURITY NO.: None
17. INFORMANT AND ADDRESS: Mr. Henry Polacek Jr. Delmont Station Severn, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Cerebral Hemorrhage — Interval Between Onset and Death: 4 hrs.

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) ....

(c) ....

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY | (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

11 AM 30 45 m

22. I hereby certify that I attended the deceased from Oct 22, 1954, to Oct 22, 1954, that I last saw the deceased alive on Oct 22, 1954 and that death occurred at 3.45 P m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

Leon C Bock M.D. Annapolis Md 10-22-54

23. BURIAL, CREMATION, REMOVAL (Specify): Burial | DATE: Oct. 25 1954 | NAME OF CEMETERY OR CREMATORY: Glen Haven Cemetery | LOCATION (City, town, or county) (State): Glen Burnie Md.

DATE REC'D BY LOCAL REG.: Oct. 25, 1954 | REGISTRAR'S SIGNATURE: Wm. J. French Dy. Dr. of Hlth. | 24. FUNERAL DIRECTOR: T. E. Singleton | ADDRESS: Glen Burnie, Md.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 09048

09008

CERTIFICATE OF DEATH

Reg. Dist. No. 27

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15 8-51

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Homewood Convalescent Home

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY Charles
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN La Plata
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED: (Type or Print) (First) R. (Middle) L. (Last) Reich

4. DATE OF DEATH: (Month) Oct. (Day) 31 (Year) 1954

5. SEX: M.

6. COLOR OR RACE: W.

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: Sept. 16 1878

9. AGE last birthday: 76 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life. Never if retired): Retired School Teacher

10b. KIND OF BUSINESS OR INDUSTRY: Public School

11. BIRTHPLACE (State or foreign country): Frederick Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Raymond C. Reich

14. MOTHER'S MAIDEN NAME: Phoebe De Lashmutt

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 212-01-7587

17. INFORMANT & ADDRESS: Elinor G. J. Reich, La Plata, Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

Immediate cause (a) A terminal Coronary Heart Disease — Interval Between Onset and Death: Unknown

DUE TO

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (b) Generalized Arteriosclerosis — Unknown

DUE TO

(c)

II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION: 20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify) PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) M. INJURY OCCURRED While at work ☐ Not while at work ☐ HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 15 May 1954, to 31 Oct. 1954, that I last saw the deceased alive on 31 Oct. 1954, and that death occurred at 4:45 P.M., from the causes and on the date stated above.

SIGNATURE Edward L Beck (DEGREE OR TITLE) M D ADDRESS 41 Southgate Ave Annapolis DATE SIGNED 11/3/54

23. BURIAL, CREMATION REMOVAL (Specify): Burial DATE THEREOF Nov. 3 1954 NAME OF CEMETERY OR CREMATORY Mt. Olivet LOCATION (City, town, or county) Frederick Md. (State)

DATE REC'D BY LOCAL REG. 11/2/54 REGISTRAR'S SIGNATURE Julia J Casey Mrs. J. French

24. FUNERAL DIRECTOR Hunt & Ryon, Waldorf, Md. ADDRESS

MARYLAND 09009

STATE DEPARTMENT OF HEALTH 19049

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH
COUNTY: Anne Arundel — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Annapolis
LENGTH OF STAY (in this place): 4 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Anne Arundel General

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Pennsylvania — COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Rural A A Co Md
STREET ADDRESS (If rural, give location): BreadWater Rd Arnold Md

3. NAME OF DECEASED (Type or Print): (First) EMANUEL (Middle) (Last) RESH

4. DATE OF DEATH: (Month) Oct (Day) 8 (Year) 1954

5. SEX: M

6. COLOR OR RACE: W

7. SINGLE, MARRIED, (WIDOWED), DIVORCED, (Specify)

8. DATE OF BIRTH: May 11 1876

9. AGE last birthday: 78 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Brick Layer

10b. KIND OF BUSINESS OR INDUSTRY: Retired

11. BIRTHPLACE (State or foreign country): Pennsylvania

12. CITIZEN OF WHAT COUNTRY? USA.

13. FATHER'S NAME: John Resh

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): (If year, give war or dates of service): no

16. SOCIAL SECURITY NO.: 173-03-8492

17. INFORMANT AND ADDRESS: Kinze A Bloxford

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Coronary occlusion

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Hypertensive cardiovascular disease

(c)

INTERVAL BETWEEN ONSET AND DEATH

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 10-5, 1954, to 10-5, 1954, that I last saw the deceased alive on 10-5, 1954, and that death occurred at 7:40 P m., from the causes and on the date stated above.

SIGNATURE (Degree or title) | ADDRESS | DATE SIGNED
Waverly S. Green Jr. M.D. | Severna Park, Md | 10-8-54

23. BURIAL, CREMATION, REMOVAL (Specify) | DATE | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) (State)
Burial | Oct 11-54 | Lancaster Co | Lancaster Pa

DATE REC'D BY LOCAL REG. | REGISTRAR'S SIGNATURE | 24. FUNERAL DIRECTOR | ADDRESS
October 11, 1954 | Wm L French | Samuel A Funk & Son | Elm Furnace Md
L. D. Sheeba, asst.

MARGIN RESERVED FOR BINDING

OCT 14 1..
BUREAU V. ..

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09010

CERTIFICATE OF DEATH

Reg. Dist. No. 09050 21

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

1. PLACE OF DEATH:
COUNTY A A MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) — LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS U.S.Naval Hospital Annapolis, Maryland

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md COUNTY AA
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
STREET ADDRESS (If rural give location)

3. NAME OF DECEASED (Type or Print): (First) Baby Girl (Middle) (Last) ROBINSON

4. DATE OF DEATH: (Month) Oct. (Day) 5 (Year) 19 54

5. SEX: F

6. COLOR OR RACE: N

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): S

8. DATE OF BIRTH: 5 October 1954

9. AGE last birthday yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours 5 Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Md

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: William R. Robinson

14. MOTHER'S MAIDEN NAME: Helena Chew

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT & ADDRESS: U.S.N.H. Records

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

7767

IMMEDIATE CAUSE (A) Immaturity #774 — INTERVAL BETWEEN ONSET AND DEATH: 5 Hrs.

ANTECEDENT CAUSE (S) DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION: 19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY M.

21E. INJURY OCCURRED While at work [ ] Not while at work [ ]

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 10-5, 1954, to 10-5, 19 54 that I last saw the deceased alive on 10-5, 19 54, and that death occurred at 2358 M, from the causes and on the date stated above.

SIGNATURE James A Hodges M.D. ADDRESS U.S.Naval Hospital DATE SIGNED 10-6-54

23. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial — DATE THEREOF: 10-8-54 — NAME OF CEMETERY OR CREMATORY: Brewer Hill — LOCATION (City, town, or county) (State): Annapolis, Md.

DATE REC'D BY LOCAL REGISTRAR: Oct. 8, 1954 — REGISTRAR'S SIGNATURE: M. C. Council

24. FUNERAL DIRECTOR — ADDRESS: William Reese II - 108 Washington St - Annapolis, Md.

RECEIVED
OCT 11 1954
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 09051

09056 **CERTIFICATE OF DEATH** Reg. Dist. No. 28

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15—10-53

1. PLACE OF DEATH:
COUNTY Anne Arundel MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville
LENGTH OF STAY (in this place) 6 months
HOSPITAL OR INSTITUTION OR STREET ADDRESS Crownsville State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Baltimore City
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore City
STREET ADDRESS (If rural give location) 1352 Whatcoat Street

3. NAME OF DECEASED: (Type or Print) (First) George (Middle) Bernard (Last) Ross

4. DATE OF DEATH: (Month) 10 (Day) 3 (Year) 19 54

5. SEX: Male

6. COLOR OR RACE: Negro

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: 1903?

9. AGE last birthday 51? yrs. IF UNDER 1 YEAR Months — Days — IF UNDER 24 HRS. Hours — Min. —

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Unknown

10B. KIND OF BUSINESS OR INDUSTRY: Unknown

11. BIRTHPLACE (State or foreign country): Unknown

12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) Unk. (If Yes, give war or dates of service) Unk.

16. SOCIAL SECURITY NO. Unk.

17. INFORMANT & ADDRESS: Hospital Records

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

IMMEDIATE CAUSE (A) Pulmonary Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: Few minutes

ANTECEDENT CAUSE (S) DUE TO Far advanced Pulmonary Tuberculosis — Known to us since 9/15/54

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION: — 19B. MAJOR FINDINGS OF OPERATION — 20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) — 21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) — 21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY M. — 21E. INJURY OCCURRED While at work [ ] Not while at work [ ] — 21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 4/2 , 19 54 to 10/3 , 19 54 that I last saw the deceased alive on 10/3 , 19 54, and that death occurred at 11:15 p.m., from the causes and on the date stated above.

SIGNATURE [signature] M. D. ADDRESS Crownsville, Md. DATE SIGNED 10/4/54

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial — DATE THEREOF Oct. 6, 1954 — NAME OF CEMETERY OR CREMATORY Mt. Auburn — LOCATION (City, town, or county) Baltimore (State) Md

DATE REC'D BY LOCAL REGISTRAR 10-5-54 — REGISTRAR'S SIGNATURE A. W. Hedrick — 24. FUNERAL DIRECTOR Special Funeral Home ADDRESS 1631 Druid Hill Ave

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 09052

09057 CERTIFICATE OF DEATH Reg. Dist. No. 27

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15—10-5[illegible]

1. PLACE OF DEATH:
COUNTY Anne Arundel MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ft Geo G Meade
LENGTH OF STAY (in this place) 2 years
HOSPITAL OR INSTITUTION OR STREET ADDRESS U.S.Army Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY -
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore
STREET ADDRESS (If rural give location) 2908 Shirey Avenue

3. NAME OF DECEASED: (First) Mary (Middle) Elizabeth (Last) Russ

4. DATE OF DEATH: (Month) October (Day) 29 (Year) 1954

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): Married

8. DATE OF BIRTH: 23 March 1896

9. AGE last birthday: 58 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10B. KIND OF BUSINESS OR INDUSTRY: -

11. BIRTHPLACE (State or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: John S. Boyle

14. MOTHER'S MAIDEN NAME: Alice Nash

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service) -

16. SOCIAL SECURITY NO. unknown

17. INFORMANT & ADDRESS: Son: Walter M. Gill, 3517 Pelham Ave., Balto., 13, Md.

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

IMMEDIATE CAUSE (A) Coronary Heart Disease

ANTECEDENT CAUSE (S) DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) Pulmonary Edema DUE TO

(C)

INTERVAL BETWEEN ONSET AND DEATH

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.

21E. INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 2 Oct ., 1954, to 29 Oct ., 1954, that I last saw the deceased alive on 29 Oct ...., 1954, and that death occurred at 2230 M, from the causes and on the date stated above.

SIGNATURE Bruce R Brown
BRUCE R. BROWN, CAPT., MC
ADDRESS M. D. Ft GG Meade, Md.
DATE SIGNED 29 Oct 54

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial
DATE THEREOF 2 Nov 54
NAME OF CEMETERY OR CREMATORY Woodlawn
LOCATION (City, town, or county) (State) Baltimore County, Md.

DATE REC'D BY LOCAL REGISTRAR 1 Nov 54
REGISTRAR'S SIGNATURE T. A. GORDON, CWO, USA

24. FUNERAL DIRECTOR Loring Beers
ADDRESS Balto., Md.

09011 09053

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 Reg. Dist.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. .....

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A - 5 - 53

1. PLACE OF DEATH:
COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN DOA Annapolis
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS DOA Anne Arundel General Hosp

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Anne Arundel
CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Severna Park
STREET ADDRESS (If rural, give location) Severna Park Post Office

3. NAME OF DECEASED: (Type or Print) (First) ALDEWIN (Middle) WESLEY (Last) SAPPINGTON 3rd

4. DATE OF DEATH (Month) OCTOBER (Day) 9 (Year) 19 54

5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Single	Sept. 13, 1934	20 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired):	10b. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country):	12. CITIZEN OF WHAT COUNTRY?
Laborer	Yacht Yard	Severna Park, Maryland	USA

13. FATHER'S NAME: ALDWIN WESLEY SAPPINGTON JR

14. MOTHER'S MAIDEN NAME: MYRTLE KROTH

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)	(If Yes, give war or dates of service)	16. SOCIAL SECURITY NO.:	17. INFORMANT & ADDRESS:
NO	NO	215-34-2105	same as Mr. Aldewin W. Sappington Jr., Father- # 2

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

			INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a)	Shock- secondary hemorrhage	sudden
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last	DUE TO (b)	compound comminuted fracture of right femor	
	DUE TO (c)	compound fracture of right elbow Internal injuries	

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION:	19b. MAJOR FINDING OF OPERATION:	20. AUTOPSY? Yes ☐ No ☒

21a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.	21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY Street	21c. (City or town) (County) (State) nr. Severna Park Anne Arundel Maryland

21d. TIME (Month) (Day) (Year) (Hour) OF INJURY October 9 54 Noon P.M.	21e. INJURY OCCURRED While at work ☐ Not while at work ☒	21f. HOW DID INJURY OCCUR? Hit tree when thrown from Motorcyle

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☐, and find that death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE [signature] M. D. CHIEF MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAM. ☐ DATE SIGNED 10/9/54

23. BURIAL, CREMATION, REMOVAL (Specify):	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	Oct. 12, 54	Glen Haven Cemetery	Glen Burnie, Maryland

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Oct. 12, 1954	[signature]	Ben L. Hopping and Son	Annapolis, Md.

OCT 14 1

VS. A15 8-51

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09058 09054

CERTIFICATE OF DEATH

Reg. Dist. No. 22

1. PLACE OF DEATH:
COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL) OR TOWN Laurel Glenn
LENGTH OF STAY (in this place) 50 years
HOSPITAL OR INSTITUTION OR STREET ADDRESS Jackson Grove Road

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md COUNTY Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Laurel Glenn
STREET ADDRESS (If rural, give location) Jackson Grove Road

3. NAME OF DECEASED: (Type or Print) (First) FREDERICKA (Middle) KATHERINE (Last) SCHULTZ

4. DATE OF DEATH: (Month) October (Day) 6 (Year) 1954

5. SEX: F.

6. COLOR OR RACE: W

7. SINGLE, (MARRIED,) WIDOWED, DIVORCED, (Specify):

8. DATE OF BIRTH: Feb 7 1876

9. AGE last birthday: 78 yrs. IF UNDER 1 YEAR: Months / Days; IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: ~~Paul Adolph Schultz~~ Ewald Roese

14. MOTHER'S MAIDEN NAME: ~~Roese~~ Amelia Hoffman

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) no (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.: no

17. INFORMANT & ADDRESS: Wilhelmina Betz Glenn Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

Immediate cause (a) Cerebral hemorrhage — Interval between onset and death: 1 day

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last
DUE TO (b) Arteriosclerosis, general
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death. Cardiac decompensation

19a. DATE OF OPERATION: none

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) M.

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 2/24/54 to 10/6/54 that I last saw the deceased alive on 10/5/54, and that death occurred at 7 A.M., from the causes and on the date stated above.

SIGNATURE (DEGREE OR TITLE) ADDRESS DATE SIGNED
Bobby L. Jones MD 5 Central Ave SE Glen Burnie 10/6/54

23. BURIAL, CREMATION, REMOVAL (Specify): Burial
DATE THEREOF: October 9 1954
NAME OF CEMETERY OR CREMATORY: Glen Haven Cemetery
LOCATION (City, town, or county) (State): Glen Burnie, Md.

DATE REC'D BY LOCAL REG. Oct 7, 1954
REGISTRAR'S SIGNATURE: Clara Haslup by D'Alba Trat.

24. FUNERAL DIRECTOR: T Livingston ADDRESS: Glen Burnie, Md.

RECEIVED
OCT 11 1954
BUREAU V. S.

09055

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09059

CERTIFICATE OF DEATH

Reg. Dist. No.

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15—10-5

1. PLACE OF DEATH
COUNTY A.A. MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brooklyn
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS 3/15 Franklin St

2. USUAL RESIDENCE (HOME) OF DECEASED.
STATE Md. COUNTY
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brooklyn Park
STREET ADDRESS (If rural give location) 5/15 Franklin St.

3. NAME OF DECEASED: (Type or Print) (First) Charlotte (Middle) M. (Last) Shannon

4. DATE OF DEATH: (Month) 10 (Day) 19 (Year) 1954

5. SEX: F.

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): W

8. DATE OF BIRTH: 10.9.75

9. AGE last birthday: 79 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework

10B. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): Baltimore

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Elias Bangs.

14. MOTHER'S MAIDEN NAME: Esther Lewis

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No
(If Yes, give war or dates of service)

16. SOCIAL SECURITY NO

17. INFORMANT & ADDRESS: Family - Same

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

IMMEDIATE CAUSE (A) Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 1½ hours?

ANTECEDENT CAUSE (S)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.

(B) DUE TO Coronary sclerosis Angina pectoris — 8 years.

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.

21E. INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July, 1952, to Oct., 19 54 that I last saw the deceased alive on 10.27.54, and that death occurred at 2.50 A M, from the causes and on the date stated above.

SIGNATURE Jerry Summers M. D. ADDRESS 1045 Edgewood Ave DATE SIGNED 10.30.54

23. BURIAL, CREMATION, REMOVAL (SPECIFY) B. DATE THEREOF 11.1.54 NAME OF CEMETERY OR CREMATORY Loudon Park LOCATION (City, town, or county) Balto. (State)

DATE REC'D BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE C. W. Hedrick

24. FUNERAL DIRECTOR Jas. L. McCarthy ADDRESS 130 E. Fort Ave.

MARYLAND STATE DEPARTMENT OF HEALTH

09060

09056

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 2-3

MARGIN RESERVED FOR BINDING. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. PLEASE WRITE PLAINLY, WITH UNFADING INK.

VS. A15

1. PLACE OF DEATH: COUNTY Anne Arundel. MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Linthicum Hts. | LENGTH OF STAY (in this place) 35 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS 500 W. Deg and Rd.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Same. COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Same.
STREET ADDRESS (If rural give location) Same

3. NAME OF DECEASED (Type or Print): (First) Mary (Middle) Pulliam (Last) Starr
4. DATE OF DEATH: (Month) Oct. (Day) 9 (Year) 1954

5. SEX: Female. | 6. COLOR OR RACE: White | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) | 8. DATE OF BIRTH: Mar 15 1864 | 9. AGE last birthday: 90 yrs. | If under 1 year: Months / Days | If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife. | 10b. KIND OF BUSINESS OR INDUSTRY: At home | 11. BIRTHPLACE (State or foreign country): West Virginia | 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: T. Pulliam | 14. MOTHER'S MAIDEN NAME: Rebecca Deakins

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | (If yes, give war or dates of service): no | 16. SOCIAL SECURITY NO.: none | 17. INFORMANT: Mrs. Cupia Loughrie

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Carcinoma of the Lung & Throat. — 1 yrs.

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Carcinoma of the Breast. — 4 yrs.

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. —

19a. DATE OF OPERATION: 1950 | 19b. MAJOR FINDINGS OF OPERATION: Carcinoma of the Breast | 20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify): no | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR? —

22. I hereby certify that I attended the deceased from ..., 19 50, to Oct 9, 19 54, that I last saw the deceased alive on Oct 8, 19 54, and that death occurred at 3 a.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) | ADDRESS | DATE SIGNED

James S. Billingsley, M.D. | 104 Central Ave. The Bunns Bldg | Oct 9, 1954

23. BURIAL, CREMATION, REMOVAL (Specify): Burial | DATE THEREOF: Oct 14 | NAME OF CEMETERY OR CREMATORY: Lauderdale | LOCATION (City, town, or county) (State): Balto. Md

DATE REC'D BY LOCAL REG.: Oct 11 - 54 | REGISTRAR'S SIGNATURE: [illegible] | 24. FUNERAL DIRECTOR: Stewart Memorial Co. | ADDRESS: Balto.

Duck

09012

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09057 Reg. Dist. No. 2

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH:
COUNTY ANNE ARUNDEL — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
LENGTH OF STAY (in this place) 8 Days
HOSPITAL OR INSTITUTION OR STREET ADDRESS Annapolis Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Balto. COUNTY
CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN Annapolis
STREET ADDRESS (If rural, give location) 643 Pace St

3. NAME OF DECEASED: (Type or Print) (First) SYMORE (Middle) (Last) SIEMMONS.

4. DATE OF DEATH (Month) Oct (Day) 26 (Year) 1954

5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE Last birthday:	IF UNDER 1 YEAR: Months	Days	IF UNDER 24 HRS.: Hours	Min.
Male	Col.	Single	April-19-1905	49 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired):	10b. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country):	12. CITIZEN OF WHAT COUNTRY?
Laborer	Trucking Company	Baltimore	USA

13. FATHER'S NAME:	14. MOTHER'S MAIDEN NAME:
Unkown	Unkown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)	16. SOCIAL SECURITY NO:	17. INFORMANT & ADDRESS:
No		John Richard Brown 2047 North East Ave

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Fracture Sternum - Fracture	
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last	DUE TO (b) Dislocation Cervical Spine C-6-C-7	8 days.
	DUE TO (c) Cord Injury -	

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION:	19b. MAJOR FINDING OF OPERATION:	20. AUTOPSY?
10/18/54	See - 18	Yes ☐ No ☑

21a. EXTERNAL CAUSE WAS PRIMARY ☑ or CONTRIBUTING ☐ CAUSE OF DEATH.	21b. PLACE (Home, farm, factory, OF street, office bldg., etc. INJURY Highway	21c. (City or town, (County) (State)
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY 10 18 54 P M.	21e. INJURY OCCURRED While at work ☑ Not while at work ☐	21f. HOW DID INJURY OCCUR? Auto Accident

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☐, and find that death resulted from: Natural causes ☐, Accident ☑, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE [signature] M. D. CHIEF MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAM. ☑ DATE SIGNED 10/26/54

23. BURIAL, CREMATION, REMOVAL (Specify):	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	10/29/54	Arbutus Mem. Park	Arbutus Balt. Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
10/27/54	[signature]	Elroy O. Wilson	1000 Brantley Ave

VS. A15A - 5 - 53

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

09058

MARYLAND 09013

STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

Reg. Dist. No. ... 1 ...

M

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH: COUNTY Anne Arundel Co. MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis Md
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS A. A. Gen Hosp

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md COUNTY A. Arundle Beach Rd Severna Pk
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Box 313 Gen
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) (First) Mary (Middle) Bowers (Last) Snyder

4. DATE OF DEATH (Month) 10 (Day) 2 (Year) 1954

5. SEX F | 6. COLOR OR RACE W | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married | 8. DATE OF BIRTH 3-25-22 | 9. AGE last birthday 32 yrs. | If under 1 year: Months, Days | If under 24 hrs: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) S Carolina | 12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Leonard Bowers. | 14. MOTHER'S MAIDEN NAME Janie Peak

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service) | 16. SOCIAL SECURITY NO. 248-01-4704 | 17. INFORMANT AND ADDRESS Wilmer Snyder

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Chronic pyelonephritis

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

INTERVAL BETWEEN ONSET AND DEATH: 10 yrs?

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July, 1954, to Oct, 1954, that I last saw the deceased alive on Oct 2, 1954, and that death occurred at 7:55 p.m., from the causes and on the date stated above.

SIGNATURE Irene H Truitt M.D. (Degree or title) ADDRESS Severna Park Md DATE SIGNED Oct 3 1954

23. BURIAL, CREMATION / REMOVAL (Specify) Burial | DATE 10-5-54 | NAME OF CEMETERY OR CREMATORY Glen Haven Cem | LOCATION (City, town, or county) (State) Rutledge Hgy

DATE REC'D BY LOCAL REG. 10-4-54 | REGISTRAR'S SIGNATURE A. W. Hiers M.D. | 24. FUNERAL DIRECTOR Edward Tomlinson | ADDRESS Balto 30 Md

VS

MARYLAND 09061

09059
STATE DEPARTMETT OF HEALTH

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH
COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
LENGTH OF STAY (In this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Route 2 Box 393

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE Maryland COUNTY A. A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
STREET ADDRESS (If rural, give location) Route 2 Box 393

3. NAME OF DECEASED (Type or Print) (First) Bessie (Middle) (Last) Driggs

4. DATE OF DEATH (Month) 10 (Day) 17 (Year) 1954

5. SEX Female

6. COLOR OR RACE Col.

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) M.

8. DATE OF BIRTH 4-5-1894

9. AGE last birthday 60 yrs. | If under 1 year Months | Days | If under 24 hrs. Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife

10b. KIND OF BUSINESS OR INDUSTRY Home

11. BIRTHPLACE (State or foreign country) Maryland

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME ? Jones

14. MOTHER'S MAIDEN NAME ? Jones

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT AND ADDRESS (Mr. Ray Driggs) - Annapolis, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

250X

Immediate cause (a) Intestional Obstruction (Partial) — 6 wks

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Tumor G.I. tract (type unknown) — 2 mos

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION None

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8-3 ..., 1954, to 10-17 ..., 1954, that I last saw the deceased alive on 10-17, 1954, and that death occurred at 1:15 p.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

Faye W. Miller M.D. 11 Carroll C. 10-21-54

23. BURIAL, CREMATION, REMOVAL (Specify) | DATE | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) (State)

Burial | 10-21-54 | Broadneck | Gibsonia, Md.

DATE REC'D BY LOCAL REG. 10/17/54 | REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR | ADDRESS

William Reese, II - 108 Washington St. Annapolis, Md.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 09062 09060

CERTIFICATE OF DEATH

Reg. Dist. No. ..

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 50

1. PLACE OF DEATH:
COUNTY Anne Arundel MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS U. S. Naval Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md. COUNTY
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis
STREET ADDRESS (If rural give location) 1412 North Fulton Ave.

3. NAME OF DECEASED: (Type or Print) (First) Sheldon (Middle) Anthony (Last) Summerset

4. DATE OF DEATH: (Month) October (Day) 14 (Year) 19 51

5. SEX: M

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): Married

8. DATE OF BIRTH: [illegible]

9. AGE last birthday yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Sailor

10B. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Sheldon Summerset

14. MOTHER'S MAIDEN NAME: Rachel Vicl

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) — (If Yes, give war or dates of service) —

16. SOCIAL SECURITY NO. None

17. INFORMANT & ADDRESS: Father, 1412 North Fulton Ave.

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

IMMEDIATE CAUSE (A) Crushing chest — INTERVAL BETWEEN ONSET AND DEATH: D O A

ANTECEDENT CAUSE (B) DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) Aspirated Vomitus — D O A

(C) DUE TO

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION: | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) Street

21C. WHERE DID INJURY OCCUR? (City or town) (County) Anne Arundel, (State) Md.

21D. TIME OF INJURY (Month) October (Day) 14 (Year) 19 51 (Hour) [illegible] M.

21E. INJURY OCCURRED While at work ☐ Not while at work ☒

21F. HOW DID INJURY OCCUR? Automobile

22. I hereby certify that I attended the deceased from [illegible], 19..., to [illegible], 19..., that I last saw the deceased alive on [illegible], 19[illegible] and that death occurred at [illegible] M, from the causes and on the date stated above.

SIGNATURE Howard C Humphrey ADDRESS [illegible] DATE SIGNED [illegible]

M. D.

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | DATE THEREOF [illegible] | NAME OF CEMETERY OR CREMATORY Baltimore National Cemetery | LOCATION (City, town, or county) Baltimore, (State) Maryland

DATE REC'D BY LOCAL REGISTRAR 18 October 1951 | REGISTRAR'S SIGNATURE T. A. Collo., C.H.O., USA | 24. FUNERAL DIRECTOR Arlington E. Phipps, Inc. | ADDRESS [illegible] Md.

OCT
BUREAU U. S

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 69061

09063

CERTIFICATE OF DEATH

Reg. Dist. No. 28

1. PLACE OF DEATH:
COUNTY Anne Arundel MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville
LENGTH OF STAY (in this place) 4yr. 1 2mos.
HOSPITAL OR INSTITUTION OR STREET ADDRESS Crownsville State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Baltimore City
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore City
STREET ADDRESS (If rural give location) Unknown

3. NAME OF DECEASED: (Type or Print) (First) Frances (Middle) (Last) Tate

4. DATE OF DEATH. (Month) 10 (Day) 24 (Year) 19 54

5. SEX: Female

6. COLOR OR RACE: Negro

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) Single

8. DATE OF BIRTH: 1890?

9. AGE last birthday 64? yrs. IF UNDER 1 YEAR, Months — Days — IF UNDER 24 HRS., Hours — Min. —

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Domestic

10B. KIND OF BUSINESS OR INDUSTRY: Housework

11. BIRTHPLACE (State or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME: Nowell Tate

14. MOTHER'S MAIDEN NAME: Lucinda Tate

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) Unk. (If Yes, give war or dates of service) Unk.

16. SOCIAL SECURITY NO. Unk.

17. INFORMANT & ADDRESS: Hospital Records

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

IMMEDIATE CAUSE (A) Hypertensive arteriosclerotic heart disease — INTERVAL BETWEEN ONSET AND DEATH: 4 years

ANTECEDENT CAUSE (B) DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION: — — — —

19B. MAJOR FINDINGS OF OPERATION — — — — — — —

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) — — — —

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State) — — — — — — — — — —

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) — — — — — — — M.

21E. INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR? — — — — — — — — — —

22. I hereby certify that I attended the deceased from 9/2 , 19 50 to 10/24 , 19 54 that I last saw the deceased alive on 10/24 , 19 54 , and that death occurred at 5:05 PM, from the causes and on the date stated above.

SIGNATURE [signature] M. D. ADDRESS Crownsville, Md. DATE SIGNED 10/25/54

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | DATE THEREOF 10/28/54 | NAME OF CEMETERY OR CREMATORY Warsaw | LOCATION (City, town, or county) (State) Warsaw Va.

DATE REC'D BY LOCAL REGISTRAR 10-25-54 | REGISTRAR'S SIGNATURE K M Joyce

24. FUNERAL DIRECTOR Geo. S. Nelson ADDRESS 1303 Greenmount Ave. Balto. Md.

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15—10-5[illegible]

OCT
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 09062

09064 CERTIFICATE OF DEATH Reg. Dist. No. 27

1. PLACE OF DEATH
COUNTY Anne Arundel MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ft. Meade, Md.
LENGTH OF STAY (in this place) 3 Mos.
HOSPITAL OR INSTITUTION OR STREET ADDRESS USAH, Ft. Meade, Md.

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Florida COUNTY Manatee
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bradenton
STREET ADDRESS (If rural give location) 2808 Manatee Avenue

3. NAME OF DECEASED: (Type or Print) (First) Wallace (Middle) (Last) Tervin III

4. DATE OF DEATH: (Month) October (Day) 30 (Year) 1954

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single

8. DATE OF BIRTH: 29 Oct 54

9. AGE last birthday yrs | IF UNDER 1 YEAR Months | Days 1 | IF UNDER 24 HRS. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): -

10B. KIND OF BUSINESS OR INDUSTRY: -

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Wallace Tervin Jr.

14. MOTHER'S MAIDEN NAME: Mary H. Touchton

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) - (If Yes, give war or dates of service) -

16. SOCIAL SECURITY NO. -

17. INFORMANT & ADDRESS: Father 8579th AAU, Off Stu Det, Ft Holabird, Md.

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

77½ X

IMMEDIATE CAUSE (A) Prematurity

ANTECEDENT CAUSE (S) DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO

(C)

INTERVAL BETWEEN ONSET AND DEATH: 1 day

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY M.

21E. INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 29 Oct, 1954, to 30 Oct, 1954, that I last saw the deceased alive on 30 Oct 1954, and that death occurred at 2207 M, from the causes and on the date stated above.

SIGNATURE Joseph S. Ardinger JOSEPH S ARDINGER M. D.

ADDRESS Fort Meade

DATE SIGNED 30 Oct 54

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial

DATE THEREOF 2 Nov 54

NAME OF CEMETERY OR CREMATORY Post Cemetary

LOCATION (City, town, or county) (State) Fort Meade, Md.

DATE REC'D BY LOCAL REGISTRAR 1 Nov 54

REGISTRAR'S SIGNATURE Zalinda T.A. GORDON CWO USA

24. FUNERAL DIRECTOR ADDRESS Chap. Thomas Doyle, Ft GG Meade, Md.

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15—10-54

4111

09065 09063

MARYLAND

STATE DEPARTMETT OF HEALTH

CERTIFICATE OF DEATH

Reg. Dist. No. 28

1. PLACE OF DEATH: COUNTY Anne Arundel — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Crownsville
LENGTH OF STAY (In this place) 1 yr. 10mos.
HOSPITAL OR INSTITUTION OR STREET ADDRESS Crownsville State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland — COUNTY Baltimore City
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore City
STREET ADDRESS (If rural, give location) 415 Oxford Street ✓

3. NAME OF DECEASED (Type or Print)	(First)	(Middle)	(Last)	4. DATE OF DEATH	(Month)	(Day)	(Year)
	Richard		Thomas		10	20	19 54

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
Male	Negro	Married	1873?	81? yrs.	—	—	—	—

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Track walker
10b. KIND OF BUSINESS OR INDUSTRY: R.R.
11. BIRTHPLACE (State or foreign country): Md.
12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME: Sam Thomas
14. MOTHER'S MAIDEN NAME: Julianna Green

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No
(If yes, give war or dates of service) Unk.
16. SOCIAL SECURITY No. 705-07-4784
17. INFORMANT AND ADDRESS: Hospital Records

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

A 22.1 Immediate cause (a) Chronic Myocarditis — Interval between onset and death: Known to us since 12/12/52

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)
(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Generalized Arteriosclerosis

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
— — —	— — —	Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
— — — — — —	— — — — —	— — — — — — — —		

TIME OF INJURY (Month)	(Day)	(Year)	(Hour)	INJURY OCCURRED While at Work ☒ Not While At work ☒	HOW DID INJURY OCCUR?
— — — — — —			m.		— — — — — — — — — —

22. I hereby certify that I attended the deceased from 12/12, 1952, to 10/20, 1954, that I last saw the deceased alive on 10/20, 1954, and that death occurred at 8:25 p.m., from the causes and on the date stated above.

SIGNATURE [signature] (Degree or title) ADDRESS Crownsville, Md. DATE SIGNED 10/21/54

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	Oct. 25, 1954	Arbutus Memorial Park	Arbutus Md.

DATE REC'D BY LOCAL REG. 1
REGISTRAR'S SIGNATURE ✓
24. FUNERAL DIRECTOR Mrs Katie R. Williams ADDRESS 322 N. Schroeder St.

MARGIN RESERVED FOR BINDING

09066 09064

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

Reg. Dist. No. .....

Items 8,9,Film G172 10-25-54 et

1. PLACE OF DEATH: COUNTY Anne Arundel; CITY OR TOWN Crownsville; LENGTH OF STAY (in this place) 6½ mo; HOSPITAL OR INSTITUTION OR STREET ADDRESS Crownsville State Hosp.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md; COUNTY; CITY OR TOWN Baltimore; STREET ADDRESS (If rural, give location) 123 N. Bond St.

3. NAME OF DECEASED (Type or Print): (First) James (Middle) Thompson (Last)

4. DATE OF DEATH: (Month) 10 (Day) 9 (Year) 1954

5. SEX M

6. COLOR OR RACE Col.

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) single

8. DATE OF BIRTH 1/4/1909

9. AGE last birthday 45 yrs. If under 1 year: Months; Days. If under 24 hrs.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer

10b. KIND OF BUSINESS OR INDUSTRY Ox Manual

11. BIRTHPLACE (State or foreign country) Fairfield S. C.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Joe Thompson

14. MOTHER'S MAIDEN NAME Schanette Silver

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT AND ADDRESS Crownsville State Hosp.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Cardiac failure

Antecedent cause(s) (b) Cardio vascular disease

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)

INTERVAL BETWEEN ONSET AND DEATH: 5 days

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 3-22-, 1954, to 10-9-, 1954, that I last saw the deceased alive on 10-9-, 1954, and that death occurred at 4:30 A.M., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

Crownsville State Hosp. 10-9-54

23. BURIAL, CREMATION, REMOVAL (Specify) Burial

DATE 10-11-54

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county) (State)

Brookleigh Gdns

DATE REC'D BY LOCAL REG. 10-13-54

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR ADDRESS

1040 Bentley Rd

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 09065

09067 # CERTIFICATE OF DEATH

Reg. Dist. No. ..

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH:
COUNTY A. A. MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brooklyn Park
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS 4306 Belle Grove

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md. COUNTY A.A.
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brooklyn Park
STREET ADDRESS (If rural give location) 4306 Belle Grove

3. NAME OF DECEASED: (Type or Print) (First) Julia (Middle) E. (Last) Turner

4. DATE OF DEATH: (Month) 10 (Day) 30 (Year) 1954

5. SEX: F

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): W

8. DATE OF BIRTH: 10/17/87

9. AGE Last birthday: 67 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): Housework

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): Nebraska.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: ? Fry

14. MOTHER'S MAIDEN NAME: ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO:

17. INFORMANT & ADDRESS: Family - Same

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) ..... Coronary thrombosis
DUE TO

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) .. Coronary insuffic.
DUE TO

(c)

Interval Between Onset And Death

11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: None

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Feb. 1952, to Oct., 1954, that I last saw the deceased alive on Oct. 29, 1954, and that death occurred at 9:30 AM. from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

[signature] M.D. 3904 S. Hanover St. 11-1-54

23. BURIAL, CREMATION, REMOVAL (Specify) DATE THEREOF 11/3/54 NAME OF CEMETERY OR CREMATORY Glen Haven LOCATION (City, town, or county) Balto (State)

DATE REC'D BY LOCAL REGISTRAR REGISTRAR'S SIGNATURE [signature]

24. FUNERAL DIRECTOR [signature] ADDRESS 130 E. Fort Ave

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09014 **CERTIFICATE OF DEATH** Reg. Dist. No. 09066

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

1. PLACE OF DEATH:
COUNTY Anne Arundel — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
LENGTH OF STAY (in this place) One month
HOSPITAL OR INSTITUTION OR STREET ADDRESS U.S. Naval Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md. COUNTY Balto. City
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore
STREET ADDRESS (If rural give location) 3620 Greenmount Avenue

3. NAME OF DECEASED: (Type or Print) (First) FREDERICK (Middle) WILLIAM (Last) TWELE

4. DATE OF DEATH: (Month) Oct. (Day) 11 (Year) 1954

5. SEX: Male

6. COLOR OR RACE: Cauc

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: March 18, 1893

9. AGE last birthday: 61 yrs. IF UNDER 1 YEAR: Months / Days. IF UNDER 24 HRS.: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Electrician

10B. KIND OF BUSINESS OR INDUSTRY: U.S. Navy

11. BIRTHPLACE (State or foreign country): Baltimore, Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Frederick W. Twele

14. MOTHER'S MAIDEN NAME: Mary Flaherty

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) Yes (If Yes, give war or dates of service) WWII

16. SOCIAL SECURITY NO. Unknown

17. INFORMANT & ADDRESS: Hospital Records

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

IMMEDIATE CAUSE — (A) Thrombosis, thrombotic, cerebral #332 — INTERVAL BETWEEN ONSET AND DEATH: 9 days

ANTECEDENT CAUSE (S) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. — DUE TO (B) Diabetes, mellitus 260 — 1 year

DUE TO (C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.

21E. INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 10-11, 1954 to 10-11, 1954, that I last saw the deceased alive on 10-11, 1954, and that death occurred at 8:20 M, from the causes and on the date stated above.

SIGNATURE Philip O. Kleb — ADDRESS M. D. USNH, Annapolis, Md. — DATE SIGNED 10-12-54

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial — DATE THEREOF Oct. 15, 1954 — NAME OF CEMETERY OR CREMATORY Baltimore National — LOCATION (City, town, or county) (State) Baltimore, Maryland

DATE REC'D BY LOCAL REGISTRAR October 14, 1954 — REGISTRAR'S SIGNATURE J. M. French, Deputy

24. FUNERAL DIRECTOR P. Livingston — ADDRESS Anne Arundel Co. Md.

OCT
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 09067

09068

CERTIFICATE OF DEATH

Reg. Dist. No. 21

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH:
COUNTY G. A. Co. MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN High Point.
LENGTH OF STAY (in this place) 2 yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS Edgewood & Robert Aves.

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md. COUNTY G. A. Co.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN High Point
STREET ADDRESS (If rural give location) Edgewood & Robert Aves.

3. NAME OF DECEASED: (Type or Print) (First) Anna (Middle) M. (Last) Tydings

4. DATE OF DEATH: (Month) Oct. (Day) 4 (Year) 1954

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed

8. DATE OF BIRTH: abt. 2/1/1893

9. AGE, last birthday: abt. 61 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): Charlady

10b. KIND OF BUSINESS OR INDUSTRY: Bank

11. BIRTHPLACE (State or foreign country): Balto. Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John Curran

14. MOTHER'S MAIDEN NAME: Mary Stumps

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

16. SOCIAL SECURITY No.:

17. INFORMANT & ADDRESS: Madeline A. Irvin Edgewood & Robert Aves, ~~High Point G.A.Co.~~

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset And Death
Immediate cause	(a) Congestive Heart Failure	4 years
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. DUE TO	(b) Coronary Thrombosis	6 years
DUE TO	(c) Diabetes mellitus	20 years

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Arteriosclerosis obliterans, lower extremities — 2 years

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Nov. 12, 1952 to Oct. 4, 1954, that I last saw the deceased alive on Oct. 4, 1954, and that death occurred at 4:30 P.M., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

C. M. McLaughlin M.D. Residence Med. Oct. 4, 1954

23. BURIAL, CREMATION, REMOVAL (Specify) Burial — DATE THEREOF 10/8/1954 — NAME OF CEMETERY OR CREMATORY Lorraine Park — LOCATION (City, town, or county) (State) Woodlawn Balto. Co. Md.

DATE REC'D BY LOCAL REGISTRAR 10-6-54 — REGISTRAR'S SIGNATURE A. W. Hedrick

24. FUNERAL DIRECTOR — ADDRESS Flynn & Fleming 1426 Light St.

151

MARYLAND 09015

09068
STATE DEPARTMETT OF HEALTH

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH
COUNTY: Anne Arundel — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Annapolis
LENGTH OF STAY (In this place):
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Anne Arundel General Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland — COUNTY: Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Weems Creek nr Annapolis,
STREET ADDRESS (If rural, give location): DuBois Rd.

3. NAME OF DECEASED (Type or Print): (First) JOSEPHINE (Middle) ANN (Last) VALLILLO

4. DATE OF DEATH: (Month) October (Day) 12, (Year) 1954

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Single

8. DATE OF BIRTH: Sept. 29, 1948

9. AGE last birthday: 6 yrs. If under 1 year: Months. If under 24 hrs.: Days, Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none

10b. KIND OF BUSINESS OR INDUSTRY: none

11. BIRTHPLACE (State or foreign country): Annapolis, Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: John M. VALLILLO

14. MOTHER'S MAIDEN NAME: LIllian SILVIO

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) ***
(If year, give war or dates of service) ****

16. SOCIAL SECURITY NO.: None

17. INFORMANT AND ADDRESS: Mr. John M. Vallillo-father- same as # 2

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Brain Tumor - Primary — Interval between onset and death:

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) with Hypothalamic Syndrome — 4 mo -

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes XX No

21. ACCIDENT / SUICIDE / HOMICIDE (Specify):

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY:

(CITY OR TOWN) (COUNTY) (STATE):

TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June, 1954, to 12 Oct, 1954, that I last saw the deceased alive on 12 Oct, 1954, and that death occurred at 1:45 p.m., from the causes and on the date stated above.

SIGNATURE Philip O'Brien (Degree or title) M.D. ADDRESS 95 E. Main St DATE SIGNED 13 Oct 54

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE: Oct. 15, 1954 — NAME OF CEMETERY OR CREMATORY: St. Mary's Cemetery — LOCATION (City, town, or county) (State): Annapolis, Maryland

DATE REC'D BY LOCAL REG.: Oct. 15, 1954 — REGISTRAR'S SIGNATURE: [signature]

24. FUNERAL DIRECTOR: Ben L. Hopping and Son — ADDRESS: Annapolis, Md.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 09069

09069 **CERTIFICATE OF DEATH** Reg. Dist. No. 21

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15—10-53 2104

1. PLACE OF DEATH:
COUNTY Anne Arundel MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort George G. Meade
LENGTH OF STAY (in this place) 10 years
HOSPITAL OR INSTITUTION OR STREET ADDRESS U.S. Army Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY —
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore
STREET ADDRESS (If rural give location) 2[illegible] Parkwood Avenue

3. NAME OF DECEASED: (Type or Print) (First) Daniel (Middle) [illegible] (Last) Watkins

4. DATE OF DEATH: (Month) October (Day) 3 (Year) 1954

5. SEX: Male
6. COLOR OR RACE: Negro
7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): Single
8. DATE OF BIRTH. October 3, 1954
9. AGE last birthday yrs | IF UNDER 1 YEAR Months | Days | IF UNDER 24 HRS. Hours 7 | Min. 2

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Weldon Harrison Watkins Jr.
14. MOTHER'S MAIDEN NAME: Leola S. Valentine

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT & ADDRESS. Mother, 2908 Parkwood Ave. Baltimore MD

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

IMMEDIATE CAUSE (A) Respiratory and Cardiac Failure — INTERVAL BETWEEN ONSET AND DEATH: 7 hrs 9 min

ANTECEDENT CAUSE (S) DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) Prematurity DUE TO — 7 hrs 9 min

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION: none
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY M.
21E. INJURY OCCURRED While at work ☐ Not while at work ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 3 October 1954, to 3 October 1954 that I last saw the deceased alive on 3 October, 1954, and that death occurred at 2:[illegible] P M, from the causes and on the date stated above.

SIGNATURE [illegible] M. D. ADDRESS Fort George G. Meade DATE SIGNED 3 October 1954

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial
DATE THEREOF 5 October 54
NAME OF CEMETERY OR CREMATORY Post Cemetery
LOCATION (City, town, or county) (State) Fort George G. Meade, Maryland

DATE REC'D BY LOCAL REGISTRAR 5 Oct 1954
REGISTRAR'S SIGNATURE T. A. Gordon
T. A. GORDON, CWO, USA
24. FUNERAL DIRECTOR Chaplain Ritter ADDRESS Fort George G. Meade

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09070 **CERTIFICATE OF DEATH** Reg. Dist. No. 09670

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 5

1. PLACE OF DEATH:
COUNTY Anne Arundel MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort George G. Meade
LENGTH OF STAY (in this place) 10 years
HOSPITAL OR INSTITUTION OR STREET ADDRESS U. S. Army Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore
STREET ADDRESS (If rural give location) 2908 Parkwood Avenue

3. NAME OF DECEASED: (First) David (Middle) (Last) Watkins
4. DATE OF DEATH: (Month) October (Day) 3 (Year) 1954
5. SEX: Male
6. COLOR OR RACE: Negro
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single
8. DATE OF BIRTH: October 3, 1954
9. AGE last birthday yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours 7 Min. 27

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Weldon Harrison Watkins Jr.
14. MOTHER'S MAIDEN NAME: Leola S. Valentine

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT & ADDRESS: Father, 2908 Parkwood Ave. Baltimore

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
771 X IMMEDIATE CAUSE	(A) Respiratory and Cardiac Failure	7 hrs 27min
ANTECEDENT CAUSE (S) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.	DUE TO (B) Prematurity	7hrs 27 in
	DUE TO (C)	

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION: none
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.
21E. INJURY OCCURRED While at work ☐ Not while at work ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 3 October 1954, to 3 October 1954, that I last saw the deceased alive on 3 October, 1954, and that death occurred at 2:15 PM, from the causes and on the date stated above.

SIGNATURE Harriet E. Washburn, M.D.
ADDRESS M.O. Fort George G. Meade
DATE SIGNED 3 October 1954

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial
DATE THEREOF 5 October 54
NAME OF CEMETERY OR CREMATORY Post Cemetery
LOCATION (City, town, or county) (State) Fort George G. Meade, Md.

DATE REC'D BY LOCAL REGISTRAR 5 October 1954
REGISTRAR'S SIGNATURE T. A. Gordon, Jr., LSA
24. FUNERAL DIRECTOR Wm. A. Battle
ADDRESS Fort George G. Meade

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 09071

09071 **CERTIFICATE OF DEATH** Reg. Dist. No. [illegible]

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 5

1. PLACE OF DEATH:
COUNTY [illegible] MARYLAND
CITY (If outside corporate limits, write RURAL OR TOWN and give nearest town) [illegible]
LENGTH OF STAY (in this place) [illegible]
HOSPITAL OR INSTITUTION OR STREET ADDRESS U. S. Army Hospital (T)

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE [illegible] COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore 18, Maryland
STREET ADDRESS (If rural give location) 1011 Deepwood Road

3. NAME OF DECEASED: (Type or Print) (First) Florence (Middle) Caroline (Last) Watt

4. DATE OF DEATH: (Month) October (Day) 6 (Year) 19 54

5. SEX: Female | 6. COLOR OR RACE: White | 7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): Married | 8. DATE OF BIRTH. 21 October 1899 | 9. AGE last birthday 55 yrs | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): New York

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: John A. Hager

14. MOTHER'S MAIDEN NAME: Christina Schwendeman

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) | (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT & ADDRESS: Major Marion Watt

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

IMMEDIATE CAUSE (A) Acute Pulmonary [illegible]

ANTECEDENT CAUSE (B) DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) Arteriosclerotic Cardiovascular Disease.

(C) DUE TO

INTERVAL BETWEEN ONSET AND DEATH
(A) 30 Sept 54
(B) 6 Oct 54
(C) Unknown

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION: None | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M. | 21E. INJURY OCCURRED While at work ☐ Not while at work ☐ | 21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 30 Sept, 1954, to 6 October 1954, that I last saw the deceased alive on 6 October, 1954, and that death occurred at 1143 M, from the causes and on the date stated above.

SIGNATURE Delma W Caldwell Major MC ADDRESS DATE SIGNED
CALDWELL, MAJOR, MC
M. D.

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | DATE THEREOF 8 October 1954 | NAME OF CEMETERY OR CREMATORY Columbia Gardens | LOCATION (City, town, or county) (State) Arlington Virginia

DATE REC'D BY LOCAL REGISTRAR 8 October 1954 | REGISTRAR'S SIGNATURE [illegible] M.D. | 24. FUNERAL DIRECTOR Rinaldi Funeral Home ADDRESS

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BUREAU V

09072 MARYLAND STATE DEPARTMENT OF HEALTH 09072

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No. 24

1. PLACE OF DEATH: COUNTY Anne Arundel — STATE MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Pasadena — LENGTH OF STAY (In this place) 47 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS Light St. Avenue

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE — COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN
STREET ADDRESS ~~Rural~~ (If rural, give location)

3. NAME OF DECEASED (Type or Print): (First) John (Middle) Calvin (Last) WAY
4. DATE OF DEATH (Month) October (Day) 2 (Year) 1954
5. SEX M.
6. COLOR OR RACE White
7. ~~SINGLE~~, MARRIED, ~~WIDOWED~~, ~~DIVORCED~~ (Specify) married.
8. DATE OF BIRTH 7/13/92
9. AGE last birthday 62 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mail Handler.
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Tennessee
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME John Way.
14. MOTHER'S MAIDEN NAME Nancy Cass.
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 219-17-0420
17. INFORMANT AND ADDRESS Lillian M. Way (Wife)

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Coronary Occlusion — sudden

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last
(b)
(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH.
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at work ☐ Not while at work ☐
HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ___, Inspection X, Inquiry ___ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes X, accident ___, suicide ___, homicide ___, undetermined ___.*

SIGNATURE (Degree or title) ADDRESS DATE SIGNED
Gustave A Pambrun M.D. Assistant Medical Examiner Glen Burnie, Md. 10/2/54

~~FINAL~~ CREMATION (Specify) — DATE THEREOF 10-5-54 — NAME OF CEMETERY OR CREMATORY Glen Haven Memorial — LOCATION (City, town, or county) Glen Burnie — (State) Md

DATE REC'D BY LOCAL REG. Oct. 4, 1954 (Oct 5, 1954) — REGISTRAR'S SIGNATURE L. J. D'Alba — 24. FUNERAL DIRECTOR John M. Taylor Sons — ADDRESS Annapolis Md.

MARGIN RESERVED FOR BINDING

USE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct and especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09073 **CERTIFICATE OF DEATH** Reg. Dist. No. .. ... .

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 5

1. PLACE OF DEATH.
COUNTY Anne Arundel MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville
LENGTH OF STAY (in this place) 5½ months
HOSPITAL OR INSTITUTION OR STREET ADDRESS Crownsville State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Baltimore City
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore City
STREET ADDRESS (If rural give location) 2315 Hunter Street

3. NAME OF DECEASED: (Type or Print) (First) James (Middle) H. (Last) Webster

4. DATE OF DEATH: (Month) 10 (Day) 24 (Year) 19 54

5. SEX: Male

6. COLOR OR RACE: Negro

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed

8. DATE OF BIRTH: Nov. 9, 1874

9. AGE last birthday 79 yrs. IF UNDER 1 YEAR Months — Days — IF UNDER 24 Hrs. Hours — Min. —

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Unknown

10B. KIND OF BUSINESS OR INDUSTRY: Unknown

11. BIRTHPLACE (State or foreign country): District of Columbia

12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No or unk.) Unk. (If Yes, give war or dates of service) Unk.

16. SOCIAL SECURITY NO. Unk.

17. INFORMANT & ADDRESS: Hospital Records

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

IMMEDIATE CAUSE (A) Uremia — INTERVAL BETWEEN ONSET AND DEATH: 5 months

ANTECEDENT CAUSE (S) DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH: Generalized Arteriosclerosis — Known to us since 5/5/54

19A. DATE OF OPERATION: - - - - -

19B. MAJOR FINDINGS OF OPERATION - - - - - - - - - - - - - - -

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) - - - - - - -

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State) - - - - - - - - - - - - - -

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) - - - - - - M.

21E. INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR? - - - - - - - - - - - - - - - -

22. I hereby certify that I attended the deceased from 5/5, 19 54, to 10/24, 19 54 that I last saw the deceased alive on 10/24, 19 54, and that death occurred at 10:00 M., from the causes and on the date stated above.

SIGNATURE [signature] M. D.

ADDRESS Crownsville, Md.

DATE SIGNED 10/25/54

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial

DATE THEREOF Oct. 29, 1954

NAME OF CEMETERY OR CREMATORY Mt. Auburn Cem.

LOCATION (City, town, or county) (State) Baltimore Co., Md.

DATE REC'D BY LOCAL REGISTRAR 10-27-54

REGISTRAR'S SIGNATURE [signature]

24. FUNERAL DIRECTOR Holland Funeral Home

ADDRESS 1631 Druid Hill Ave.

09016 09074

MARYLAND

STATE DEPARTMETT OF HEALTH

CERTIFICATE OF DEATH

Reg. Dist. No. 21

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH: COUNTY Anne Arundel — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Glen Burnie — LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Anne Arundel General Hosp

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md — COUNTY A A
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Severna Park
STREET ADDRESS R.D. 2 - Box 374 (If rural, give location)

3. NAME OF DECEASED (Type or Print): (First) MARGARET (Middle) C. (Last) WESTERLUND

4. DATE OF DEATH: (Month) Oct (Day) 26 (Year) 1954

5. SEX: Female — 6. COLOR OR RACE: White — 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married — 8. DATE OF BIRTH: March 21 1900 — 9. AGE last birthday: 54 yrs. — If under 1 year: Months, Days; If under 24 hrs.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife — 10b. KIND OF BUSINESS OR INDUSTRY: At Home — 11. BIRTHPLACE (State or foreign country): Boston Mass. — 12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Joseph A Owen — 14. MOTHER'S MAIDEN NAME: Catherine A O'Brien

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) — (If year, give war or dates of service) — 16. SOCIAL SECURITY NO. — 17. INFORMANT AND ADDRESS: Helge S. Westerlund R.D. 2-Box 374 Severna Pk

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

420.0
Immediate cause (a) Myocardial infarction — 10 da

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Hypertensive arteriosclerotic heart disease

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION — 19b. MAJOR FINDINGS OF OPERATION — 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) — PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY — (CITY OR TOWN) — (COUNTY) — (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURRED While at Work ☐ Not While At work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 10-16, 1954, to 10-26, 1954, that I last saw the deceased alive on 10-25, 1954, and that death occurred at 6:05 a.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) — ADDRESS — DATE SIGNED
Waverly S. Green, Jr. M.D. — Severna Park, Md. — 10-26-54

23. BURIAL, CREMATION, REMOVAL (Specify) Burial — DATE 10-29-54 — NAME OF CEMETERY OR CREMATORY Dan Lawn Mem — LOCATION (City, town, or county) Eastern Ave Baltimore (State) Md.

DATE REC'D BY LOCAL REG. 10-27-54 — REGISTRAR'S SIGNATURE L — 24. FUNERAL DIRECTOR — ADDRESS
Ray C Miller Inc - 2431 E. Oliver St

09074

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Reg. Dist. 09075

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 26

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15A - 5 - 53

1. PLACE OF DEATH:
COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL OR TOWN and give nearest town) Deale
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md COUNTY A. A.
CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Deale
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED: (Type or Print) (First) George (Middle) Moonis (Last) Whittington

4. DATE OF DEATH (Month) October (Day) 18 (Year) 19 54.

5. SEX: male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): single

8. DATE OF BIRTH: Dec 4 - 1918

9. AGE last birthday: 35 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired):

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Deale Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Joseph Whittington

14. MOTHER'S MAIDEN NAME: Viola Marshall Deale

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) —

16. SOCIAL SECURITY No.: —

17. INFORMANT & ADDRESS: Marion N. Marshall Deale

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

Immediate cause (a) Myocardial infarction DUE TO

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (b) congenital heart disease DUE TO (c)

INTERVAL BETWEEN ONSET AND DEATH

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION:

19b. MAJOR FINDING OF OPERATION:

20. AUTOPSY? Yes ☐ No ☒

21a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY

21c. (City or town) (County) (State)

21d. TIME (Month) (Day) (Year) (Hour) OF INJURY M.

21e. INJURY OCCURRED While at work ☐ Not while at work ☐

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and find that death resulted from: Natural causes ☐, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE Louis Linn Grant M.D. M. D.

CHIEF MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAM. ☒

DATE SIGNED 10/19/54

23. BURIAL, CREMATION, REMOVAL (Specify): Burial

DATE THEREOF 10/20/54

NAME OF CEMETERY OR CREMATORY Deale

LOCATION (City, town, or county) (State) Deale A.A Co Md

DATE REC'D BY LOCAL REG. Oct. 19-54

REGISTRAR'S SIGNATURE D. Belle Dent

24. FUNERAL DIRECTOR ADDRESS Hardesty Funeral Home Galesville Md

09075 09076

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 Reg. Dist.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. [illegible]

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A - 5 - 53

1. PLACE OF DEATH:
COUNTY: Anne Arundel — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Crownsville
LENGTH OF STAY (in this place): 4yrs.10mos.
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Crownsville State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE: Maryland COUNTY: Calvert
CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): Sunderland
STREET ADDRESS (If rural, give location): None listed

3. NAME OF DECEASED: (Type or Print) (First) Joseph (Middle) S. (Last) Wills.

4. DATE OF DEATH (Month) Oct (Day) 12 (Year) 1954

5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	Negro	Single	9/14/23	31 yrs.	—	—	—	—

10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired):	10b. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country):	12. CITIZEN OF WHAT COUNTRY:
Laborer	Unknown	Maryland	U. S.

13. FATHER'S NAME:	14. MOTHER'S MAIDEN NAME:
Frank Wills	Mary Rice

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)	16. SOCIAL SECURITY NO.:	17. INFORMANT & ADDRESS:
Yes WWII	Unk.	Hospital Records

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

Immediate cause (a) Acute dilitation Heart. — INTERVAL BETWEEN ONSET AND DEATH: Sudden

DUE TO

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last

(b) DUE TO

(c)

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION: — 19b. MAJOR FINDING OF OPERATION: — 20. AUTOPSY? Yes ☐ No ☐

21a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH. — 21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY — 21c. (City or town) (County) (State)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. — 21e. INJURY OCCURRED While at work ☐ Not while at work ☐ — 21f. HOW DID INJURY OCCUR?

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☑, Inspection ☐, Inquiry ☐, and find that death resulted from: Natural causes ☑, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE C. Lynn Ruark M. D. — CHIEF MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAM. ☑ — DATE SIGNED 10/13/54

23. BURIAL, ~~CREMATION~~, ~~REMOVAL~~ (Specify):	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
	10/20/54	National Cemetery	Balto. City	Md

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
10/19/54	H. W. Hedrick L.L.	Charles Law	802 Madison Ave. Baltimore, Md.

09017

Item 21, File Clerk 10-18-54 ens

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Reg. Dist. 09077

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 21

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Give correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
COUNTY Anne Arundel — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis — LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS —

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md. COUNTY Balt.
CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN Baltimore
STREET ADDRESS (If rural, give location) 199 Newburg Ave.

3. NAME OF DECEASED: (Type or Print) (First) Dennis (Middle) Meredth (Last) Wright

4. DATE OF DEATH (Month) 10 (Day) 2 (Year) 1954

5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Single	1-2-1928	26 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired):	10b. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country):	12. CITIZEN OF WHAT COUNTRY?
?	?	Maryland	

13. FATHER'S NAME: William E. Wright

14. MOTHER'S MAIDEN NAME: Mabel T. Pearsall

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) World War II

16. SOCIAL SECURITY NO.:

17. INFORMANT & ADDRESS: W. E. Wright 199 Newburg Ave. Baltimore Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

Immediate cause (a) Multiple Lacerations Chest & — DUE TO — Interval Between Onset and Death: Instant

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (b) Accidental Hemorrhage — DUE TO

(c) Severed L. Carotid - Subclavian Vessels & Nerves.

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION:	19b. MAJOR FINDING OF OPERATION:	20. AUTOPSY? Yes ☐ No ☐

21a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.	21b. PLACE (Home, farm, factory, OF street, office bldg., etc.) INJURY City Dock	21c. (City or town) Annapolis Harbor (County) (State)
21d. TIME OF INJURY (Month) 10 (Day) 2 (Year) 54 (Hour) 1 P.M.	21e. INJURY OCCURRED While at work ☐ Not while at work ☒	21f. HOW DID INJURY OCCUR? Fell from bow of boat Fire overboard, Cut by Propeller

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☐, and find that death resulted from: Natural causes ☐, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE C. Lamm Tuttle M. D. — CHIEF MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAM. ☒ — DATE SIGNED 10/2/54

23. BURIAL, CREMATION, REMOVAL (Specify):	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	10-5-54	Park Heights	Brunswick Md

DATE REC'D BY LOCAL REG. Oct. 2, 1954 — REGISTRAR'S SIGNATURE W. O. Brunck — 24. FUNERAL DIRECTOR C. N. Fuhr & Bro — ADDRESS Brunswick Md

VS. A15A - 5 - 53

RECEIVED
OCT 6 1954
BUREAU V. S.

09018

09678

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 Reg. Dist.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 21

1. PLACE OF DEATH:
COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis | LENGTH OF STAY (in this place) 10
HOSPITAL OR INSTITUTION OR STREET ADDRESS DOA Anne Arundel General Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Anne Arundel
CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN Annapolis
STREET ADDRESS (If rural, give location) 179 West Street

3. NAME OF DECEASED: (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month) (Day) (Year)
ROBERT	J	ZINDORF	October 19, 1954

5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE Last birthday:	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married	July 3, 1895	59 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired):	10b. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country):	12. CITIZEN OF WHAT COUNTRY?
President	Retail Oil Company	Annapolis, Maryland	USA

13. FATHER'S NAME:	14. MOTHER'S MAIDEN NAME:
Joseph G. Zindorf	Catherine Angelbeck

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)	16. SOCIAL SECURITY No.:	17. INFORMANT & ADDRESS:
Yes WW I	218-26-7142	Mrs Catherine J. Zindorf- Wife- Same as # 2

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH: (Interval Between Onset and Death)

Immediate cause (a) Coronary Occlusion — Sudden
DUE TO

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last
(b)
DUE TO
(c)

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION:	19b. MAJOR FINDING OF OPERATION:	20. AUTOPSY? Yes ☐ No ☒
0		

21a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.	21b. PLACE (Home, farm, factory, OF street, office bldg., etc.) INJURY	21c. (City or town) (County) (State)
	Office	Annapolis, Anne Arundel, Maryland

21d. TIME (Month) (Day) (Year) (Hour) OF INJURY	21e. INJURY OCCURRED While at work ☒ Not while at work ☐	21f. HOW DID INJURY OCCUR?
Oct. 19 54 3 p M.		Natural causes

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE [signature] M. D. CHIEF MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAM. ☒ DATE SIGNED 10/21/54

23. BURIAL, CREMATION, REMOVAL (Specify):	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	Oct. 22 54	St. Mary's Cemetery	Annapolis, Maryland

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
10/22/54	[signature]	Ben L. Hopping and Son	Annapolis, Md.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15A - 5 - 53

RECEIVED
OCT 25 1954
BUREAU V. S.